FROM THE STANDPOINT OF POLICYMAKERS: AN INSTITUTIONAL ETHNOGRAPHY INQUIRY INTO THE POLICYMAKING PROCESS TO ADDRESS HEALTH EQUITY AND SOCIAL DETERMINANTS OF HEALTH IN CANADA

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Abstract

The health of a society's population is determined by the way that society distributes its social and economic resources. This is because a high level of inequality and a wide gap in the socio-economic gradient corresponds with people's experience of poor health. Despite available evidence of increasing socio-economic and health inequities in Canada, health equity (HE) considerations are not filtering through public policies, which may explain the skewing in the distribution of social determinants of health (SDH). Various governmental and non-state actors recognize these increasing social inequalities and have considered pursuing equity in public policies. Evidence shows Canadian governments do not generally deliver on their pledges to implement HE-promoting policies. Inquiries about the incongruity between the stated institutional goal of pursuing HE in public policies and the persistent lack of it have pervaded public policy discourses.

This study attempts to fill the knowledge gap in the public policy arena between the pluralists and institutionalist explanations of inequities to improve our understanding of "how" and "why" HE/SDH concepts are not filtering through into health policies. My original contribution to knowledge is an account of how policymakers' work processes are drawn into and coordinated by a set of institutional relations of ruling. These institutional relations organize sequences of inter-related policymaking activities that link these activities to the work of others in producing or not producing policies with health equity outcomes. Using Institutional Ethnography as a method of inquiry, the study aims to highlight intrinsic institutional conceptual practices and explicate how "work" constituting policymaking is performed, influenced, and perceived in multiple institutional sites. Using mapping as an IE device, I map out institutional texts to illuminate the relations of ruling and social organization of policymaking as work. This study concludes that epistemologies rooted in hegemonic biomedical and neoliberal conceptual practices within the selected institutions dominate the ruling relations and the social organization of policymaking as work in these sites; and that, the gap between HE concepts and government's obligation to equity driven health policy for actions on SDH demonstrates a lack of commitment to act in an increasingly market-oriented and politicized policymaking environment.

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I should not forget about myself! My simple life principles dictate that once I am started on a mission, I must finish, however daunting the venture. Many have failed to start or finish. I like to start and finish. This is my testimony!

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Chapter 1: Introduction

The pursuit of health equity (HE) in society through public policy has become a fashionable consideration globally and among Canadian policymakers especially as a result of growing social inequalities in health (Navarro, 2008; Navarro et al., 2006; M. J. Smith, 2015; Whitehead, 2007b). There exists a body of literature documenting apparent commitments across all Canadian governmental jurisdictions to health promotion and decreasing health inequalities through HE policies (Health Council of Canada, 2010).

The constellation of intergovernmental efforts is accompanied by declarations that HE considerations require urgent attention to the distribution of social and economic resources among Canadians. The goal of such effort would be to reduce the pervasive material and social deprivation that makes some Canadians experience unacceptable living and working conditions despite living in a wealthy industrialized country (Carroll & Sapinski, 2018; Langille, 2016). Research demonstrates that since health inequalities result from the unfair and unjust differences in health determinants, they are actually inequities that come to have a profound negative impact on the health and wellbeing of individuals, communities, and the entire nation in both short and long-term (Raphael, 2010a, 2013b; Scott-Samuel & Smith, 2015; Whitehead & Popay, 2010).

The effect of these wide-ranging inequities is seen through differential morbidity and mortality rates associated with income, race, gender, geographies, age groups, and immigration history, among others. Moreover, these inequities in health manifest through mechanisms such as child poverty, food insecurity, community violence and crime, mental health and addiction, under-housing and homelessness; inequality in education and skills attainment; unemployment and unhealthy workplaces, income and wage insecurity, and so on (Jackson & Rao, 2016; Lynch, 2000; Mitrou et al., 2014; Navarro & Shi, 2001b; Pickett & Wilkinson, 2015; Raphael, 2010b; Raphael

& Bryant, 2006; Woolard et al., 2015). The realization of addressing social determinants of health (SDH) through enacting policies that achieves HE remains a pipe dream for Canada. The failure to equitably distribute resources for health across the Canadian population reflects negatively on Canada's global and country-specific health policy commitments (Commission on Social Determinants of Health, 2008; Dutton, Forest, Kneebone, & Zwicker, 2018; Raphael, Curry-Stevens, & Bryant, 2008).

More evidence reveals that despite the societal goal of obtaining equitable access to health services through public policy actions, there remain variations in how health services are reaching Canadians (Coburn, 2010; Labonté et al., 2015; Langille, 2016; Raphael, 2011). Such variations can partly explain why a sizeable number of people in jurisdictions with universal health services still encounter barriers to accessibility and utilization of services (Barsanti & Nuti, 2014). Even though the wealth of western industrialized and developed capitalist countries has increased considerably over the last few decades, health inequities have persisted and this is especially the case in Canada (Langille, 2016). These societal inequities are explained as being partly due to the rise in neoliberal capitalism built upon the Liberal welfare state type that a country has pursued throughout its development (Arts & Gelissen, 2002; Bambra, 2007; Brassolotto, Raphael, & Baldeo, 2014; Esping-Andersen, 1990, 1999; Raphael, 2013a; Raphael & Brassolotto, 2015; Saint-Arnaud & Bernard, 2003). These wide-ranging health inequities have prompted several scholars to identify the need for applying HE considerations as a means to achieving destratification and decommodification, which are key aspects in distribution of resources necessary for health (Bambra et al., 2010; Bambra, 2006; Raphael, Komakech, Bryant, & Torrence, 2019)

Furthermore, advances in the neoliberal phase of capitalism have largely intensified its influence over the distribution of social and economic resources across and within societies

through dominant market-oriented mechanisms (Harvey, 2005; Liodakis, 2005). The rate at which a nation's public policy processes are being co-opted and modified by the neoliberal ideology has compromised state interventions that could address the social inequities creating health inequities (Scott-Samuel & Smith, 2015). Policymakers within many capitalist societies now recognize that increasing unequal control over the production of wealth also skews the distribution of social and economic resources in society (Scott, 2006). Underlying these realizations, and feeling the pulse of the pervasive contradictions between market processes and achieving HE are a variety of political ideologies – Conservative and Liberal – through which Canadian politicians rationalize health inequities (Carroll & Sapinski, 2018; Schrecker & Bambra, 2015).

A proportion of Canadians still live in divided communities of the rich few and others – revealing the unequal nature of social, cultural, economic and power distribution and the politics that perpetuates such social inequities (Carroll & Sapinski, 2018). The Canadian National Advisory Council on Poverty [1] released its 2021 report of a 2019 Canadian Income Survey (CIS). This report shows that poverty in Canada declined from 14.5% in 2015 to 10.1% in 2019, highlighting a 30% poverty reduction (Government of Canada, 2022). Statistics Canada acknowledges that despite the decline in poverty rates, certain low-income Canadians including 2SLGBTQ, persons with disabilities, Indigenous people, Black Canadians, racialized Canadians, immigrants, and refuges, are still trapped in deep inequities and face high rates of poverty.

Statistics Canada (2022[2]) further highlights income inequality between the high- and low-income Canadians for third quarter of 2021. According to Statistic Canada, the household wealth

[1] Government of Canada (2022). Understanding Systems: The 2021 report of the National Advisory Council on Poverty. Retrieved June 10, 2022, from https://www.canada.ca/en/employment-social-development/programs/poverty-reduction/national-advisory-council/reports/2021-annual.html#h2.2

[2] Statistics Canada (2022). Distribution of household economic accounstf or wealth of Canadian households, third quarter 2021. Retrieved on June 10, 2022 from https://www150.statcan.gc.ca/n1/daily-quotidien/220128/dq220128b-eng.htm

reached $15.1 trillion as of the third quarter of 2021, a figure up $2.1 trillion from the third quarter of 2020. The top 20% wealthiest households held more than two-thirds (67.1%) of all net worth in Canada, while the lowest 40% held 2.8%. Income inequality is one of the stronger indicators of inequality in a society where market income is a major determinant of health (Raphael, 2016). The conference Board of Canada [3]in its 2011 report revealed that income inequality increased over 20 years such that the riches Canadians increased their share of income while the middle-class and the poorest group lost. The question of how to distribute health resources and the barriers to such actions have become the foundation of studies in HE. The concern over increasing inequities has also been a subject of inquiries about the effectiveness of welfare state arrangements, including the Canadian welfare state system (Banting & Myles, 2013, 2016; Myles & Quadagno, 2002). The concern stretches to inquiries on how the aforementioned influence health or health inequities as experienced in all its aspects, e.g., physical, mental, and social, treatments or health care, and its socio-political and economic determinants (Aggleton, 1990; Bryant, 2009).

As we explore more concepts and theories in this thesis, the nature and importance of welfare states and the politics that inform health policy will be shown to be sometimes visible but invisible more often (Arts & Gelissen, 2001; Bambra, 2007; Esping-Andersen, 2014; Esping-Andersen, 1990). There exists an emerging consensus that the anchors of health inequities in Canada are entrenched in the politics of the welfare state. This deduction is based on work by scholars who have carefully studied the welfare state character and attributed these pervasive societal inequalities – and the health inequities they cause – to the fading redistributive effect of Canadian welfare state mechanisms (Auger & Alix, 2016; Banting & Miles, 2013; Bryant, 2010; Navarro & Shi, 2001a; Raphael & Bryant, 2018).

[3] Conference Board of Canada (2011). Hot Topic: Canada Inequality. Is Canada becoming more unequl? Retrieved on June 10, 2022 from https://www.conferenceboard.ca/Files/hcp/pdfs/hot-topics/canineequality.pdf

Trends in health inequity across developed industrial countries affirm that the prevailing political ideologies of nations inform the health outcomes that their population enjoys (Coburn, 2010; Bryant, 2016; Bryant, Raphael, Schrecker, & Labonte, 2011; Brennan, 2012). Various jurisdictions have enacted their health policies and tailored them to guarantee resources for health through several prisms: as a fundamental right of every citizen to address social needs, a resource for everyday living, a precondition for economic and social production or harnessing of personal potential; and, more recently, as a market commodity (World Health Organization [WHO], 2013; Aggleton, 1990; Katz, 2004, 2005).

In contrast, Canada, like its liberal welfare state contemporaries, despite having a publicly-funded health care system, has increasingly taken the perspective that health is a commodity in the marketplace (privatization and marketization of health), and wishes its distribution to be allocated through market mechanisms (Lewis & Thorlby, 2011; Raphael, 2013a). Perhaps, this predilection could be one reason to make obtaining equity in health policy difficult (Scott-Samuel & Smith, 2015) and it could partly explain some of the equity-related tensions in Canada's universal health care system.

Scott-Samuel and Smith (2015) have challenged the ability of governments to address health inequities in the era of expanding neoliberalism without the mandate to effectively tackle power differentials and high levels of societal stratification. The consensus among many researchers is that neoliberal policies are harmful to a population's health (Labonté & Schrecker, 2007; Labonté & Stuckler, 2016; Mooney, 2012; Navarro, 2000; Smith, Bambra, & Hill, 2015), as neoliberalism renders governments helpless to enact health-equity promoting public policies because of its anti-statist effects (Panitch & Gindon, 2003; Panitch & Konings, 2009). In Canada, governments' efforts at addressing HE through policy measures have instead shaped, reproduced,

and sustained health inequities through social deprivation among children, single mothers, immigrants, Indigenous populations, people of colour, and people with disabilities (Banting & Myles, 2013, 2016b; Bryant, Raphael, Schrecker, & Labonte, 2011; Green, Riddell, & St-Hilaire, 2016; Humphries & Van Doorslaer, 2000; Patterson & Veenstra, 2016; Dennis Raphael, 2000; Vayda, Townsend, & Davidson, 1984; Veenstra & Patterson, 2016). Green, Riddell, and St-Helaire (2016) demonstrated, using various measures of income inequality among Canadian workers, that labour market incomes have steadily declined from 1976 to 2011. According to Green et al. (2016), the bottom half of income earners in the labour force experienced the least progress in income equity between 1976 to 2011, a fact corroborated by Banting and Myles (2013). The study findings by Green and colleagues have profound implications for the promotion of HE in health policy. In an economy like Canada's where income is the key determinant of how one is well integrated or excluded from society, this study confirms unequal distribution of resources.

Thus, the *problematic* in my study is the starting point of tension experienced by policymakers striving to achieve health policies promoting HE and the outcomes of policy work that does not result in HE. Decades of health policy and advocacy work may have increased knowledge as well as the acceptance of HE concepts among policymakers. Yet, while HE knowledge may have a positively changed attitude towards HE as a public policy goal for redistribution of social and economic resources necessary for health, Canadian scholars and researchers agree that social and economic inequalities have instead grown in Canada to unacceptable levels and are still mounting.

One school of thought that is favoured in this thesis suggests that such contradictions can be explained by the structuring and politics of the Canadian welfare state in ways that promote neoliberalism (Bryant, 2010; Raphael, 2013; Raphael, 2013a, 2013b; Saint-Arnaud & Bernard,

2003). This school of thought avers that Canada's failures to gain traction on securing HE through the equitable distribution of the SDH are a direct influence of it having a Liberal welfare state (Brassolotto, Raphael, & Baldeo, 2014; Raphael, 2010a; Arts & Gelissen, 2002; Esping-Andersen, 1990). As such, efforts to enact effective equity-driven public policies under the Liberal welfare system are marred by issues of power, external influence, and competing interests steeped in neoliberalism (Bambra, Fox, & Scott-Samuel, 2005a; Douglas, 2016; Farrants & Bambra, 2018; Kickbusch, Allen, & Franz, 2016; Raphael, 2015). Moreover, this thought is not only prevalent in Canada. It is a widespread observation and has been a subject of research undertaken in many countries including Australia, the UK, and the US (Farrants & Bambra, 2018b; Mackenbach, 2010; Scott-Samuel & Smith, 2015; Whitehead & Popay, 2010).

To further explicate the *problematic*, this study adopts a political economy of health approach that embodies the analysis of power and privileges in policymaking (Coburn, 2010; Doyal & Pennell, 1979; Minkler, Wallace, & McDonald, 1994; Raphael, 2015b). By applying the political economy of health perspective to study public policy, key policy actions or inactions become visible. Applying a lens of political economy of health illuminates the mechanism by which external influences and competing interests coalesce upon, shape, or subvert policymaking and policy outcomes (Bryant, 2010; Coburn, 2010; Raphael & Bryant, 2018). Scholars in the field of the political economy of health highlight that the way societies achieve health outcomes reflects the socio-economic and political structures of that society, and the inherent interests of the class that controls the power structures and means of production (Bryant, 2009; Keita, 2007; Navarro & Shi, 2001b; Raphael, 2014). Therefore, achieving HE and population health requires a deliberate effort of moderating power and privileges – a process that is inherently political and often

contested. Later, I dedicate a section for explicating the political economy of health and its explanatory relevance in illuminating health inequities contributing to HE discourses.

The primary goal of any policies that promote HE should be achieving equitable distribution of social and economic resources for health, as well as improving health outcomes for all citizens. This is more obvious, especially for a wealthy industrialized country like Canada. However, it is important to appreciate that these policies serve first and foremost, the purpose of the state and the class that governs it. Thus, Exworthy (2008) acknowledges that far from failure to enact HE policies, policymakers demonstrate relatively little understanding of the link between SDH and HE policies (and ruling class interests).

Additionally, societies often fall short of achieving equity in health when the question of power imbalances is not addressed (Dover & Belon, 2019; Navarro, 1998; Navarro & Shi, 2001b). Exworthy (2008) and Walt (1994) thus draw our attention to the interplay of context, content, process, and powers that come to shape HE policy discourses. Thus, achieving HE policy is both normative and ideological. Yet, the nature of health policy itself is complex having emerged from a process of harmonizing various dominant social, economic, and political interests operating from multiple sites and over eons. One such force is the expanding corporate interests and changing structure of governments in response to the anti-statist effects of neoliberalism. Neoliberal policies actively seek to diminish the role of the welfare state, eroding its redistributive influence, while expanding the Liberal market (Coburn, 2001; Panitch & Gindin, 2004). Arguably, civil society organizations and labour movements still play implicit and explicit roles in shaping health policies for advancing equity; however, their voices in health policy discourses are declining with the emerging forces of neoliberalism.

This study, therefore, explores the activities of actors within a web of institutional culture and entrenched traditions that galvanize the policymaking sites, practices, and processes. The goal of the study is to understand policymaking as a deliberate work enacted from within an institution where policymakers interact with each other through a constellation of coordinated actions and activities and to explicate these activities concerning their HE policy outcomes.

This thesis takes an approach that the distribution of health as a resource is a product of complex institutional interactions of political forces that operate from macro to micro levels of society (Bambra, Fox, & Scott-Samuel, 2005, 2007). Therefore, to appreciate the existence of inequities in health within and between societies, one must study how the economies of these societies are organized, the historical and structural forces that drive and sustain production, distribution, and control over power and therefore, resources (Carroll & Sapinski, 2018; Raphael, 2013b, 2015a; Raphael & Brassolotto, 2015). Furthermore, linking health inequities to the underlying societal politics or dominant interests opens a gateway to understanding health policies and the various social, economic, and political forces that shape these policies through an institutionalist purview. Hence, some scholars state that health policies are not value-free since they embody certain political ideologies (Bryant, 2009).

By exploring the history of social policy in order to understand how health policies are made in western industrialized capitalist societies, I identified the evolution of influences attributed to various political ideologies that have emerged over time and have shaped different welfare state typologies such as Liberal, Conservative, and social-democratic welfare states (Esping-Andersen, 1990, 1999). These ideological formations in turn help us discern between those welfare types capable and those that are not capable of enacting equitable health policies. Esping-Andersen's

welfare state typology, therefore, offers policy analysts a means of understanding the redistributive politics of welfare states.

Given the aforementioned background, the primary objective of this study is to apply a political economy of health theoretical framework to explore, from the standpoint of policymakers within health institutions, how their everyday work is organized and coordinated; and how the organizing of their work textually and discursively bears upon their everyday decisions in the course of making HE promoting policies. The study examines a wide range of issues central to the power and politics of HE policymaking together with the influences exerted by institutional conceptions of power.

It investigates how HE and SDH concepts are invisible in the discursive sense even when the absence of these concepts becomes conspicuous in policy outcomes. This study works within the traditions of Institutional Ethnography as espoused by Dorothy E. Smith (D. E. Smith, 1987, 2005, 2006). More so, the study explores the social relations within the Canadian public health institutional context, and how policymaking work is coordinated within and with other departments and institutions that reveal the contestation, mediation, contradictions, and resistance to a deliberate process that would contribute to HE guided health policies. It also investigates the informants' experience from the standpoint of those who identified themselves as policymakers, to reveal the *relations of ruling* that shape local and translocal experiences through text-based discourses and forms of knowledge (Devault & McCoy, 2006; D. E. Smith, 2006). Thus, "policymakers" are located through multiple sites within the institution of health (explained in Methodology section), and interviewed to explore everyday work policy, their policymaking experiences as work, institutional processes, values, and patterns of translocal activities that shape their policymaking actions (D. E. Smith, 2005). More succinct details of the process of the study

and the definition of terminologies used in Institutional Ethnography will be provided in the Methodology section of this thesis. In the next chapter, I delve into some theoretical issues that are critical to the study.

Chapter 2: Some Theoretical Considerations

This section explores the political economy of health as the theory guiding this study. It examines various facets of the political economy of health concepts that align with the method of inquiry to ensure harmony between theory, method of inquiry, data analysis, and reporting of the discoveries.

2.1 Political Economy of Health

In working with issues in HE and social determinants of health, it is necessary to be explicit about one's theoretical framework. In this thesis, I apply a political economy of health framework to understanding the barriers to achieving HE through public policy action. Political economy refers to both theories and approaches used to examine assumptions and ideologies that underlie political and state structures that affect the populace (Mantoura & Morrison, 2016). A political economy perspective in health studies necessitates considering the economy as an important part of a social whole and requires detailing the links between economic, political, and social developments (Browning & Kilmister, 2006; Navarro et al., 2006; Raphael, 2013a). According to Bryant (2009), a political economy perspective is "…vested in economic, political and social structures that influence the distribution of power and resources in a society" (p. 65).

The relevance of applying a political economy theory to the study of HE-oriented public policy is clear given that "health" itself is a contested concept in the arena of politics (Bambra et al., 2005a; Raphael, 2015b). Thus, political economy is a multidisciplinary scholarly field that includes the study of how wealth is produced and distributed locally and nationally (Moolakkattu, 2009). Wealth and health have a cyclical relation such that wealth determines health and health determines wealth. Each is a resource necessary for the other to thrive. Scholars have developed

political economy concepts and applied them to analyze the linkages between politics, economics, and health. A political economy of health literature is primarily concerned with how economic and political systems create public policies for the distribution of economic and social resources of health (Coburn, 2010; Raphael, 2015; Minkler et al, 1994; Doyal & Pennell, 1979). For clarity, political economy as a scholarly discipline usually rejects a narrow focus on "pure market" or market fundamentalism, and privileges a broader view of economic inquiry, its social purpose, and its political application (Elliott, 1994; Marx, 1887/[1992]; Stilwell, 2002). Stilwell (2002) posits that the political economy lens stresses the importance of historical processes, structural forces, and the role of institutions in shaping economic outcomes. Thus, scholars have worked towards mainstreaming the political economy as a framework used to analyze and initiate systemic changes in the status quo (Coburn & Coburn, 2007; Morgan, 1987). In addition, scholars have focused on exploring two variations of political economy common in health policy debates: 1) institutionalist; and 2) critical materialist political economy. Both institutionalist and critical materialist political economy frameworks have influenced the development of institutional ethnography as a method of inquiring institutional work processes (D E Smith, 1987; 1999; 2005, 2006).

2.2 Institutionalist Political Economy

Institutionalist political economy is concerned with how societal institutions influence policy making (Bryant, 2009; Hilgers, 2013). Institutionalists analyze politics by focusing on the role of the institutional context in which formal rules, procedures, and processes structure relationships of production (Hall, 2009; Hilgers, 2013; Peters et al., 2005; Thelen & Steinmo, 1992). The central premise of the institutionalist political economy rests on the primacy that shaping or restructuring values and policy preferences of policy actors alters economic production

(Bryant, 2009; Hilgers, 2013). According to Hilgers (2013), for institutionalists, individual actors may have the power to make choices, however, their rationality is bounded by existing institutional norms. Bryant (2009) identifies the institution as consisting of the formal rules of operation, organizational structures, and standard operating procedures. According to institutional ethnographers Mykhalovskiy and McCoy (2002), the institution is "...characterized by multiple activities of individuals, organizations, professional associations and the discourses they produce and reproduce." (p.19). Institutional activities are organized around a particular function or objective, such as health, education and housing and may occur in multiple sites (Mykhalovskiy & McCoy, 2002; E. D. Smith, 1987). Furthermore, institutions are not ideology-free, as they uphold and transmit certain ideologies and may restrict the choices available to policymakers (Bryant, 2009).

Institutionalist political economy scholars emphasize the impact of historical and socio-political factors on the evolution of economic practices and approaches. Hall and Lamont (2013) highlight some of the institutionalist debates that variously use institutionalist and cultural explanations of how neoliberal ideas emerged into government policies, public institutions, and the lives of ordinary people. The authors argue that some institutions allow some developed and developing nations to become resilient to be able to provide citizens with resources to live healthy, secure, and fulfilling – in the face of neoliberalism (Hall & Lamont, 2013). According to Hall and Lamont's (2009), institutionalist cultural analysis, inequalities in health are based not only on economic inequalities but also influenced by the structure of social relations rooted within the primacy of institutions, its control of the economic system and structure, as well as agencies within these institutions. In Box 1 below, I provide a summary of key ideas in institutionalist political economy.

Table 2. 1. Key Aspects of the Institutionalist Approach

- The primacy of organizations (institutions) and control of the economic system.
- Structure and power.
- The market as an institution/internal market.
- Concerned with institutions of production and its organization

According to Bryant (2016), there are three frequently integrated approaches within institutionalist political economy whose discussions are beyond the scope of this undertaking. These include 1) historical institutionalism – tracing how the past events may shape the future; 2) rational choice institutionalism – understanding the economic positions of political actors; and 3) sociological institutionalism – emphasizing the role of culture and norms in determining influence over individuals (Bryant, 2009). Though the integrated institutional political economy may seem comprehensive, it does not fully provide a framework for power analysis, especially countering the influence of powerful societal sectors such as corporations. Moreover, corporate and business sectors are actively engaged in influencing the public policy-making process to control the distribution of economic and social resources **(**Bryant, 2016**).** In sum, the institutionalist political economy overemphasizes rational problem solving as a component of policymaking within an institution, while neglecting how politics and ideology emerge as central to policy decisions. This lens is critiqued for facilitating the production of unjust public policies that may promote the inequitable distribution of economic and social resources (Bryant, 2016; Hall & Lamont, 2013).

2.3 Critical Materialist Political Economy

The materialist worldview acknowledges that individuals' way of life and environment shapes their ideas on how to govern society (Coburn, 2010). Materialist political economy is further divided into critical materialist political economy and historical materialist political economy. Materialist political economy is "critical" because it questions the status quo (institutions, power, class structure, etc.), and opens avenues for redressing limitations of institutionalist approaches (Coburn, 2010). According to Coburn (2010), critical materialist political economy (CMPE) presumes that people within a society may or may not be conscious of how their society works. This assumption helps policy analysts applying CMPE to challenge prevailing perceptions, beliefs, assumptions, ideologies, and ideas by unveiling new ways how to alter the status quo (Coburn, 2001, 2010). CMPE further focuses on the power imbalances among societal sectors that shape the politics, economic structures, and processes of a country (Mendley-Zambo & Raphael, 2018). Examples of this stream include studies of the corporate and business sector (Langille, 2016), and the influence of global neoliberalism over public policies that skew the distribution of, and access to resources necessary for health (Labonte and Stuckler, 2016; Harvey, 2005; Raphael, 2011a; 2015a). When applying critical materialist political economy, the concept of "materialist" is commonly used to highlight how society organizes production, with a focus on how the mode of production and class formations inform ideas and societal structures influencing the material living conditions of people (Coburn, 2010).

Historical materialist political economy (HMPE) on the other hand focuses on the analysis of visible and invisible forces that drive social formations to reveal the predominant ways in which goods and services are historically produced and distributed through social relationships over time (Coburn, 2010). Canada's current social formation is characterized by capitalist modes of production that produce goods and services for private use and distribute economic and social

resources through a Liberal market mechanism (Coburn, 2010). In the box below, key aspects of CMPE are listed.

Table 2. 2. Highlights of a Materialist Political Economy Approach

Structure: Socio-economic conditions of society

Agency: Individuals or group actions

Critical Materialist Political Economy:

- Stands outside status quo, resists existing order by asking how these came about
- Questions power relations in existing institutions and attentive to class differences
- Approaches and targets the system as a whole
- Processes part of a dynamism of change extending to the present
- Posits alternatives are more desirable
- Provides a guide to alternative world order

2.4 Intersection of Political Economy and Health

Political economy relates to health in two fundamental ways: a) how health resources are produced, controlled, and distributed; and b) the human interactions which comprise both the catalyst and consequence of that control and distribution of health resources (Keita, 2007). As an approach to health studies, political economy recognizes that health inequities are a result of social inequalities shaped by jurisdictional politics, economic structures, and processes (Coburn, 2001, 2010; Minkler et al., 1994; Raphael, 2013).

A materialist political economy entails the analysis of the economy, society, and politics as integrated structures evolving historically (Dimmelmeier, Pürckhauer, & Shah, 2016). On the other hand, the critical materialist political economy framework focuses on the analysis of underlying power, societal structures (class, social location), and processes. When power is concentrated in society, the critical materialist political economy framework is constructive in

examining how policies focusing on producing, reproducing, and maintaining inequality in the distribution of resources for health plays out for those without access to that power (Mantoura & Morrison, 2016).

The link between political economy and health policy is embedded in how the former generally directs attention to power and its influence over various societal sectors and how these sectors shape the changes in policies that influence the distribution of social, economic, and political resources in society (Coburn, 2010; Raphael, 2011a, 2013, 2015). Of interest is the growing influence of neo-liberalism, a political ideology that favours the dominance of economic markets as the driver of economic growth and resource distribution (Bryant, 2009; Coburn, 2001, 2010). As an analytical tool, political economy directs its focus in areas where the market has either failed or favored one group (class) over the other. These incidences might include unfair distribution of health resources caused by political interference in the workings of the market (Prechel & Harms, 2007).

In his appraisal of political economy, Coburn (2010) focused on the links between health and the economic, political, and social life of people in different groups, classes, regions, or societies and found an inequitable distribution of resources. Through that work, Coburn outlined a variety of political economy approaches useful to examine existing health policy typologies and assumptions that shape how these health policies are formulated. A summary of these typologies is highlighted in Table 1 below.

Table 2. 3 Health policy analytics using a variety of political economy stream

Policy type Summary	Analytical Lens
• Economic growth leads to increased resources for health, that is, improved living conditions and better health services.	Rational Choice
• Health improvement contributes to economic growth through improved labour productivity.	Materialist
• People's health is exchanged for economic growth (precarious labour, dangerous jobs, and environment expropriation through capitalist production, etc.).	Critical Materialist
• Stagnation and austerity damages health especially due to over-production leading to unemployment or underemployment.	Critical Materialist
• Certain political conditions determine who wins or loses during the distribution of health resources (the core of political economy).	Structuralist

Source: Coburn, David. (2010). Health and health care: A political economy perspective. In T. Bryant, D. Raphael, & M. Rioux (Eds.), Staying Alive: Critical perspectives on Health, Illness and Health care (2nd ed., pp. 65–92). Toronto: Canadian Scholars' Press.

2.5 Applying Critical Materialist Political Economy

The rest of this thesis adopts the CMPE as a framework for studying HE policy and its links to the SDH. The CMPE approach is chosen because of its focus on social change and its effective practice to analyze power imbalances in society resulting from major historical transformations, such as the transition from industrial to informational capitalism or from colonial to postcolonial society (Doyal & Pennell, 1979; McKinlay, 1985).

The CMPE approach pays close attention to how social totalities are created and disrupted by social class, gender, and racial divisions (Navarro, 1998; Navarro & Shi, 2001b). Applied to HE study, critical materialist political economy focuses on three critical elements: a) the economic context of growth, corporate activities, and social stratification; b) commodification, the market-oriented process of production, distribution, and consumption; and c) the role of government in mediating between these variables through public policy measures (Amick, Levine, Tarlov, & Walsh, 1995; Marmot & Bell, 2012).

Overall, political economy as a tool of analysis has been used extensively in health studies to expose health inequities and inequalities by contemporary scholars such as Leslie Doyal, John. McKinlay, Vicente Navarro (class domination, labour relations, health inequities), David Coburn (income inequality, health policy), Clare Bambra (labour relations, gender inequalities, income inequality, politics of health, and decline of the welfare system), Dennis Raphael (SDH, poverty, child poverty, immigrant health, etc.), Pat Armstrong (poverty, health care reforms), Gregg M. Olsen (labour relations; income security), Carles Muntaner (social inequalities in health, social epidemiology, health disparities; work for the organization, health care workers, health policy and mental health), Marmot and colleagues who have studied the impact of income inequality and the social gradient on society.

Studies of health inequity guided by both the political economy and critical materialist political economy have unveiled unequal distribution of health resources and linked these inequities to the role of political ideologies that shape welfare states. Major studies of health inequities using materialist explanations have taken place in the UK and include the *Black Report* (BJGP, 1981), *The Health Divide* (Whitehead & Health Education Council., 1987), Acheson's 1998 *Independent Inquiry* (Acheson & Great Britain. Her Majesty's Stationery Office., 1998), and

The Widening Gap (Shaw, 1999). For more details refer to Raphael & Bryant (2015). These studies complimented ground-breaking observations made earlier during the mid 19th century of deplorable living conditions in England by Edwin Chadwick's (1842) *Report on Sanitary Conditions of the Laboring Population of UK*; Frederick Engels' (1845), *The Condition of the Working Class in England*, and Rudolf Virchow's (1848) *Report on Typhus Epidemic in Upper Silesia* that is referenced widely in HE studies.

2.6 The Theoretical Underpinnings of this Research

In this study, I applied a materialist political economy perspective to study HE in policymaking in Canada by focusing on the interaction of politics and economic processes in society that are mediated by equity-focused public policies (Coburn, 2010; Hallstrom, 2016; Langille, 2016; Raphael, 2015a). Additionally, where this study applies critical materialist political economy as a theoretical underpinning, the purpose is to explore the nature and patterns of distribution of power in social institutions, the organizing of policymaking as work, and whether policymakers have the means to enact HE policy for actions on SDOH concepts during policymaking in an era of hegemonic neoliberalism (Bryant, 2016; McBride, 2003; Scott-Samuel & Smith, 2015). Several scholars have applied the CMPE to study the conflict between labor and capital (i.e., the corporate and business sector) to expose the inherent unequal relations between them determining the distribution of economic, cultural, and social resources with deleterious effects on health. These include, among others, Professors Vicente Navarro, Dennis Raphael, Leo Panitch, David Coburn, Carles Munta, and Clare Bambra. (Bambra et al., 2007; Coburn, 2010; Doyal & Pennell, 1979; McKinlay, 1985; Navarro, 2000; Navarro et al., 2006; Panitch & Gindin, 2014; Dennis Raphael, 2013a, 2013b, 2015c; Navarro & Shi, 2001b).

This study was undertaken to explicate the explicit and implicit influences of societal factors over the distribution of SDH. I inquired from the standpoint of policymakers' experience in the complex public policy-making processes in selected public institutional scenes across three levels of the Canadian government: the federal, three provinces, and two municipalities within Ontario. The critical political economy perspective in this study is reinforced by theories of working-class mobilization and how it shapes welfare state formations (Gøsta Esping-Andersen, 1990, 1999), and health policy (Bambra et al., 2005b; McBride, 2003; Raphael, 2015c; Scott-Samuel & Smith, 2015). It focuses on the benefits of greater degrees of decommodification, social destratification, and defamiliarization through HE promoting public policy (Wil Arts & Gelissen, 2001; Eikemo & Bambra, 2008; Eikemo, Bambra, Joyce, & Dahl, 2008; Raphael, Komakech, Bryant, & Torrence, 2018).

The materialist framework further recognizes how objective living conditions or the SDH shape health outcomes (Raphael, 2016). Graham and Kelly (2004) observed that "the health of the least and less well off in society either improves more slowly than the rest of the population or in some cases gets worse in absolute terms" (p.1). Therefore, to address inequities in health, actions through adapting policies to address HE are required to distribute SDH. Thus, the link between the theory selected for this study and the research method is derived from variations of Marxist theoretical and conceptual practices (D.E. Smith, 2005).

2.7 Justifying this Study (Knowledge Gap)

Several studies have explored policymakers' ability or inability to adopt considerations of SDH into policy activities in the UK and Australia (Carey et al., 2014; Carey & Crammond, 2015; Ellen et al., 2016; K. A. Oliver et al., 2017; Katherine E. Smith, 2014). These studies have been

mainly institutionalist (e.g., Lavis, 2002) and pluralist (e.g., Carey & Crammond, 2015; Carey, Crammond & Keast, 2014) in their approaches. Institutionalists are concerned with how institutions structure the nature of politics and political debates that lead to policy changes (Bryant, 2016). Pluralists on their part, tend to privilege the interest group dynamics as the most important unit of policy change analysis and this aligns with democratic principles (Bryant, 2016).

Most studies have identified factors preventing SDH concepts from filtering through policy activities within these two approaches (Baker et al., 2018; Innvær et al., 2002; Whitehead et al., 2004), and have highlighted how policymakers tend to prioritize ideas and respond to political pressures over available evidence during policymaking (Carey & Crammond, 2015; Koupil, 2016; Smith KE & Katikireddi, 2013). In Canada, a mismatch exists between the acceptance of the importance of SDH (Manzano & Raphael, 2010), and supportive public policies to prioritize the equitable distribution of SDH (Brassolotto et al., 2014; Raphael, 2015b; Raphael & Brassolotto, 2015; Raphael, Curry-Stevens, & Bryant, 2008c). Moreover, both pluralist and institutionalist inquiries into policymakers' experiences during the policymaking process offer several limitations: a) they assume that government often acts in the best interest of citizens; b) their focus on individual policymaker's personal experience decontextualized and deinstitutionalized policymaker's experiences from the larger social and institutional drivers of health inequities; c) pluralists and institutionalists' negate the relevance of social relations in policymaking which leads to a failure to account for power and influences from external actors such as corporations/business sectors; and d) these approaches do not account for the existing dominant ideological orientations in which SDH and HE are excluded from public policy framings (Bryant, 2016; Mendley-Zambo & Raphael, 2018; Townsend, et al., 2018).

A new approach to studying these issues seems necessary. Therefore, I employ institutional ethnography to examine policymaking processes as work from a policymakers' standpoint (D.E. Smith, 1987). Policymaking as work is contested every day within certain institutional norms, values, and practices (D.E. Smith, 1987, 2005, 2006). In this study, I examine a wide range of institutional drivers in HE policymaking to explicate institutional influences that produce and reproduce the relations of ruling, and how policymakers are aligning their everyday work with the ruling relations within the institutions or ways they might be subverting or resisting institution influences. For this kind of institutional study, Institutional Ethnography (IE) may be the most suitable approach. To date, this has not been done.

The study of HE or inequities in Canada has identified the inability of concepts associated with SDH to penetrate the policymaking process (Raphael, 2015; Exworth, 2008; Carrey & Crammond, 2015; Lavis 2002). There is a mounting body of evidence suggesting that Canadian public health officials recognize the importance of SDH as foundational to population health (Senate Sub-committee, 2009; Health Council of Canada, 2010). Most specifically, there is a growing awareness that health inequities result from the unfair distribution of SDH resources to the population (CSDH, 2008; Marmot & Bell, 2012; Marmot, 2007; McKinlay, 1985). This recognition is informed by the extant evidence showing the relevance of, and a decline in the equitable distribution of SDH which, in Canada, was first highlighted in the Lalonde report of 1974.

This progressive work by Lalonde and others after him, and commitments to promoting equity in health that Canada has signed, could be expected to guide the operations of public health agencies such as the Public Health Agency of Canada, Health Canada, Public Health Ontario, Ministry of Health and long-term care and the numerous regional health agencies through a whole-

of-government approach (Carey & Crammond, 2015; Carey et al., 2014; Raphael, 2008b, 2008a). Moreover, multiple not-for-profit agencies, Think Tanks, and research institutions have recognized and adopted HE research and SDH frameworks to promote social justice, HE, and health as a human right. There is consensus that much of what makes people ill or sick and dependent on health care services are actually outside the spheres of health care (CSDH, 2008; Mikkonen & Raphael, 2010a; Navarro, 2009).

Despite these apparent commitments, policy activities at the three levels of government – federal, provincial, and municipal – seem to take little or no explicit account of the importance of SDH in promoting HE through public policy action. Consequently, health gaps and inequitable experiences of health are increasing between members of vulnerable groups and wealthy Canadians; between locations (rural and urban), and, across the lifespan (Fong, 2018; Haddow, 2013). This social inequality is maintained by policies, or lack thereof, that influence the skewed distribution of income, wealth, and power (Carroll & Sapinski, 2018; Raphael, 2014). In the next chapter, I explore the role of health equity in the policymaking process.

Chapter 3: HE and SDH in Health Policymaking Processes

In this section, I explore HE concepts and link them to health policy debates. The purpose of this section is to guide my readers in connecting the imperatives for a HE-focused policy with actions for achieving equitable distribution of the SDH. This chapter also discusses theories that have been used to explain the policymaking process, the purpose of which is to guide my readers to understand how some policy actions result in health inequity and others do not.

3.1 Health Equity (HE)

Health Equity (HE) is an important outcome for any fair society (Whitehead, 1992, 2007a), as it refers to the absence of systematic differences in health or its social determinants among one or more disadvantaged sections of the population (Braveman, 2003; Braveman & Gruskin, 2003; Whitehead & Dahlgren, 2006). Though health is a contested concept within economic and political discourses, Eikimo and Bambra (2005) posit that the most powerful determinants of health in modern populations are social, economic, and cultural resources.

Health inequalities signify differences or variations in health status between groups in society due to unequal distribution of the aforementioned resources (Raphael, 2010c, 2013b). Inequities in health may arise when public policies fail to respond to emerging societal challenges or actively take initiative on a timely basis to place disadvantaged groups at further risk for adverse health outcomes (Braveman & Gruskin, 2003). Although our genetics, individual lifestyles, and behaviors affect our health, health is profoundly shaped by aspects of physical, social, cultural, and economic environments, i.e., SDH. The World Health Organization (WHO) describes the SDH as the conditions in which people are born, grow up, live, and work (Marmot & Wilkinson, 1999; Mikkonen & Raphael, 2010b; Navarro, 2009).

While WHO has identified several SDH, in Canada those that have been most researched are early life, education, employment and working conditions, food security, health care services, housing, income, and its distribution, Indigenous ancestry, social safety net, social exclusion, gender, race, sexual orientation, unemployment, employment security and others (Raphael, Curry-Stevens, & Bryant, 2008). The quality of these SDH and their distribution are determined by the social, economic, and political organization of society through public policy (Raphael, 2006, 2008a, 2010a, 2013a). Public policies that influence the distribution of material resources of health in society are also influenced by the politics and socio-economic forces that define that society (Raphael, 2010a; 2013a). The link between HE and SDH is that HE is the outcome and that SDH are the exposures that either contribute to or make achieving of HE difficult (Raphael, 2015; Bryant, 2016). Thus, this study explores HE/SDH concepts not as interchangeable concepts, rather as one that re-enforces each other. Health inequities arises when public policies do not address the imbalances in the distribution of power and resources in society that distribute the SDH.

Despite the importance of public policy, there is limited evidence on how policymakers' institutionalized experiences influence their perceptions of, and action on, SDH through enacting HE policy during the complex policymaking process. Furthermore, there is limited literature that has examined health policymaking as a deliberate form of work that is guided by a conscious institutional ideology guiding health policy outcomes. In section 3.2, I provide an overview of the policymaking process because this study explores policymaking as work. The section below orientates the readers to theories of policymaking with a view to build an insight into subsequent discussions guided by Institutional Ethnography about policymaking as work.

3.2 The Policymaking Process to Promote HE Concepts

According to Smith and Kantikireddi, policymaking "involves the construction and/or implementation of specific policies." (K. E. Smith & Katikireddi, 2013, p. 198). The making of the public policy highlights the importance of historical and contemporary experiences of a society or community to meet the desired outcome or solve problems. These experiences may be rooted in social and historical factors such as cultural differences, explicit or implicit struggles between various ideas, values, opportunities, institutions, and concepts of the common good and public interest. The emergence of policies may be dictated further by choice, societal or group directions, values, resource distribution, or basic social, economic, or political orientation of the society. Recognizing these issues within the plurality of ideas in society leads to a complex policy formulation process. Schon (1983) referred to this complexity as 'a swampy lowland' where solutions are confusing and problems are incapable of technical solutions (Schön, 1983). Schon argued that the role of actors (elected officials, civil society, organizations, pressure groups, experts, interested parties, lobbyists) is to map out a way from such "swampy lowland" of confusion into a policy (Schön, 1983). Hallstrom observes that public policies rarely deal with one or a single issue or problem, as complex problems create "clusters", "nodes", or "messes", many with exclusive or contradictory solutions and supporters (Hallstrom 2016, p.524).

The policy-making process may not be as complex and sophisticated as has been suggested (Baumgartner, 2016; Baumgartner, Jones, & Mortensen, 2018; Baumgartner, Jones, & Larsen-Price, 2006; Sabatier & Weible, 2014). Scholars have proposed a simplified description of stages in the policy-making cycle which include: a) problem identification, where politicians identify a priority and moot a broad outlines of solutions b) agenda-setting, when the problems are examined and defined; c) policy formulation, involving various actors; d) adoption, when the policy is arrived at through a complex process of debate and negotiations; e) implementation, when the

policy is assigned to a government agency and responsible enforcement authorities; and f) evaluation, when the policy is examined for both intended and unintended impacts, to effectively solve the problem for which it was formulated (Hallstrom, 2016; Hill, 2003; Hogwood & Gunn, 1984).

These steps form what is known as a policy cycle with evaluation leading to reconsideration of the problem (K. E. Smith & Katikireddi, 2013). K. E. Smith and Katikireddi, (2013) and Exworth and Hunter (2008) acknowledge that while the notion of policy stages offers a useful heuristic device, scholars concede that this idealistic account of policymaking does not reflect the messy reality in which multiple ideas, interested actors and values interact in a non-linear fashion and in which some stages may be ignored (Exworthy & Hunter, 2011; Smith KE & Katikireddi, 2013).

Several theories have guided analyses of public policymaking that may be relevant to contextualizing this study. Some of the theories have been used to explain why certain policies are resistant to change over time using concepts of policy inertia (historical institutionalism and path dependency theories) (Hay & Wincott, 1998; Immergut, 2016; Schmidt, 2010). *Historical Institutionalism* is the understanding that policy outcomes can only be understood by considering the historical and institutional context in which decisions are made. It takes into consideration the formal rules of political arenas, language codes, challenges of communication, and the logic of strategic solutions (Béland, 2005). These factors converge to either favour certain interpretations or political goals which political actors push forward (K.E. Smith & Katikireddi, 2013).

K.E. Smith and Katikireddi (2013) provides a clear example of how policy silos in which divisions of policymaking within organizations are divided into departments and sub-units demarcated by foci to "represents the institutionalization of past decisions and often promotes

"policy silos" that facilitate policy activities in narrow areas while preventing the development of cross-cutting policies" (p. 199). Path dependency, on the other hand, is premised upon a belief that previous policy decisions may determine the limit of possibilities for future policy decisions (Hay & Wincott, 1998; Immergut, 2016; Schmidt, 2010; K.E. Smith & Katikireddi, 2013). Thus, path dependency theory draws on temporal histories in understanding policy outcomes. Both historical institutionalism and path dependency generally predict outcomes of policy trajectories based on previous decisions and how decision-making is institutionalized and operationalized within existing structures and discourses (KE Smith & Katikireddi, 2013).

Another cluster of theories that explains the policy change process aligns with incremental policy change arguments. Lindblom and Heclo are the prominent proponents of incremental policy change/policy learning (Heclo, 1976; Lindblom, 1959, 1979). Lindblom recognizes that policymakers often "muddle" through policymaking and consider a small range of policy options that seems feasible, and then seek consensus from stakeholders (Lindblom, 1959). The incremental process allows policymakers to learn from their policymaking experiences and can adjust to unintended consequences arising from the policymaking process. Heclo posited that policymaking is a process of collective puzzlement and entails an important aspect of social learning (Heclo, 1976). Both theorists recognized the multifarious and disorienting nature of policymaking. While social learning is an important aspect of this theory, both Lindblom and Heclo recognize that individual learning may not be perfect or uniform as such it may never be reflected in the institutionalization of policymaking (Smith KE & Katikireddi, 2013). This may explain differences in how policy actors may perceive and/or interest themselves with a policy issue.

Baumgartner and Jones (1991; 1993) on the other hand, developed the punctuated equilibrium theory which upheld that public policies are characterized by prolonged stability and

punctuated by short radical change(s). The central thrust of the theory is the recognition of potential shifts in systems from one period of stasis (stability) to another at certain intervals. In the everyday policy world, punctuation occurs when a persuasive idea gains increasing attention from policymakers. This idea could be driven externally (politically) or by the inherent quality of the idea itself (K.E. Smith & Katireddi, 2013). Another relevant theory is John Kingdon's "policy streams" which evolved from observing the US policymaking process (Baumgartner, 2016; Kingdon, 1990). Kingdon realized that US policymakers could hardly explain how particular policies came about. Kingdon concluded that significant policy changes occur when three streams (policy, politics, and problems) align (Kingdon, 1990). Kingdon's distinguishing concept of policy entrepreneurs highlights the role of actors who position themselves strategically to exploit the policy windows that open when the streams converge (Kingdon, 1990).

The last theory of policy change in this category was advanced by Hall and centres on policy paradigms (Hall, 1988; 1990; 1993). Hall argued that low-level changes in policy are common and are driven by social and political elements. Hall further argues that occasional paradigmatic shifts can usher in opportunities that re-defines an issue. According to Hall, paradigmatic shifts are not driven by evidence alone because such a shift requires an associated shift in values and ideology (Hall, 1993).

Conclusively, policy analysts have realized that a policy does not necessarily arise out of evidence (Heclo, 1974; Sabatier, 1987, 1991) in alignment with changes in the underlying beliefs, values, and attitudes towards a social problem and acceptance of the claims of policy actors (Heclo, 1976; Howlett, 1991; Sabatier, 1987, 1988, 1991). In the section below, I provide a brief description of key players in shaping public policy as this section has implication for the selection of the standpoint participants for this study.

3.3 Policy Change Agents, Policy Actors, or Entrepreneurs

While there are theories that attempt to explain how policies come about, studies have also devoted time to analyze agents of policy change. Policymakers and actors are such groups or individuals who may directly or indirectly shape discourses, define policy issues, write policy statements, and so forth (Harris et al., 2020; K. E. Smith & Katikireddi, 2013). These larger groups of interested parties may form policy networks and advocacy coalitions into an "iron triangle" (Gais, Peterson, & Walker, 1984; Kingdon, 1990; Peterson, 1993). Policy theorists argue that the iron triangle enumerates a policy network formed out of stable relationships which derives policy outcomes through negotiations from within the tight-knit network (K. E. Smith & Katikireddi, 2013).

Other theorists argue that policymaking networks are diverse, fluid, and comprised of a large group of issues-interested actors that form a "policy network" (Heclo, 1974). The two extremes are bridged by Sabatier and Jenkins-Smith who developed the concept of advocacy coalition framework (ACF) that sees policy outcomes as emerging from a wide range of activities and involving a wide range of coalitions with a wide range of ideas (Colebatch, Hoppe & Dowding, 2019; Sabatier, 1987; Sabatier & Jenkins-Smith, 1993).

The ACF is premised on the observations that the shared view of the world rather than political or economical interests binds actors together in a coalition that seeks to influence policy decisions (Sabatier & Jenkins-Smith, 1993). ACF thus argues that dominant groups are unlikely to share radical ideas owing to their shared views of the work (K. E. Smith & Katikreddi, 2013). ACF predicts that with the coalition's shared views of the world, policies tend to obtain a period

of stability, however, a significant shift in the policy may occur when coalition actors switch between ideas deemed successful (Sabatier & Jenkins-Smith, 1993).

Knowledge brokers are the other influential policy change agents. Kingdon sees this group as policy entrepreneurs who work to promote preferred solutions through evidence-based policymaking (Baumgartner, 2016; Kingdon, 1990). Thus, Kingdon's approach highlights the role of knowledge producers such as Think Tanks, advocacy groups, lobbyists, researchers, and others (K.E. Smith & Katikireddi, 2013). Lastly, the role of ideas, evidence, and policy transfers in shaping policy change is enumerated by K. E. Smith and Katikireddi, (2013) as critical in policy change. The role of researchers and practitioners is highlighted in inspiring policy change through their concerted activities leading to the generation of knowledge (evidence) and knowledge translation (practice), while successful policies enacted in other jurisdictions may be transferred to another context (transfers).

According to K. E. Smith and Katikireddi (2013), the evidence translation and policy transfers are usually complex such that policymakers have shifted their attention to the role of ideas that move across geographies and contexts. By focusing on ideas, policymakers acknowledge the potential for translation and how ideas can be harnessed to capture some of the actions between politics, ethics, values, and evidence (K. E. Smith & Katikireddi, 2013).

It is important to acknowledge that public policy discourses are, however, increasingly coming under the control of corporations in this era of neoliberalism (Cumming & Li, 2013; Labonté et al., 2015; Labonté & Stuckler, 2016; Tesler & Malone, 2008). In the Canadian scene, several scholars have described how the Canadian policymaking process has been captured by corporate and private interests such that HE concepts are not filtering through public policies resulting in poor actions on SDH (Carroll & Sapinski, 2018; Clancy, 2014; McBride & Teeple,

2011; Raphael et al., 2019). Despite the resistance to HE concepts filtering through public policies, every policymaker sees the need for such policies given the decline of the welfare state system.

Chapter 4: Research Methodology

4.1 Reasserting the Purpose of this Study

The purpose of this research is to fill a knowledge gap in the public policy arena to improve the understanding of how HE and SDH concepts are contested in the HE policymaking process. The previous chapter provided an overview of policymaking theories, and HE concepts. This study is therefore about HE concepts and how they are prominent in policy discourses and absent in policy actions. The study aims to identify how institutional processes and work that constitute policymaking are organized socially and carried out in multiple institutional sites to advance the pursuit of HE. I am particularly interested in understanding how the policymaking process works within public institutions and how policymakers do their work within the conceptual frames of these institutions while enacting HE policies for distributing social and economic resources for health (SDH).

This study uses institutional ethnography as a method to explore textually-mediated ruling relations and how policymaking generates tensions and disjuncture between intentions and actions from the standpoint of policymakers. This research aims to:

a) Describe everyday (world) experiences of policymakers.
b) Trace the social processes that connect policymaking as work with the work of others on HE/SDH to discover what policymakers do and the documents (texts) governing and coordinating their work.
c) Examine the ideological and conceptual practices of power within the institution and its processes, that is, the ways that policymakers' roles are understood within these institutions and the policy outcomes expected from them.

d) Identify structures and processes of the institutions (power, interests, and influence) that influence the policymaking process.

4.2 Institutional Ethnography as a Method of Inquiry

This research applies institutional ethnography as a method of inquiry to identify societal and institutional structures and processes that socially organize policymakers' experiences to explicate policymaking as everyday work on HE policy for actions on SDH. Institutional Ethnography (IE) is a method of inquiry that details institutional processes with a focus on analyzing how people's actions and interpretations make these institutions recognizable as a particular kind of institutional context (Deveau, 2008; D. E. Smith, 1987, 1999, 2006). Through its institutional focus, the study directs attention to an empirical inquiry of coordinated and intersecting work processes taking place within multiple institutional sites (DeVault & McCoy, 2006).

IE was developed by the Canadian sociologist Dorothy. E. Smith (hereafter D.E. Smith) as a Marxist sociology for women (D. E. Smith, 1987) from "the feminist practice of consciousness-raising" (D.E. Smith, 2006, p.16). D.E. Smith later transitioned IE into sociology for people and used it for studies of phenomena by mapping the translocal relations that coordinate peoples' activities within an institution and hooked these activities to the works of others (Devault & McCoy, 2006; D. E. Smith, 1987, 1999, 2006). D.E. Smith proposes sociology that does not begin in theory but rather with people's experiences within these institutional sites. The goal of IE is to explore how people's activities are concerted (jointly arranged, planned, and carried out) and coordinated (D.E. Smith, 1999).

Thus, IE refers to the investigation of empirical linkages among local settings of everyday life, organizations, and translocal processes of administration of governance (DeVault and McCoy, 2006). In this sense, D.E. Smith identifies these empirical linkages as constituting a complex field of coordination and control she named "ruling relations" (D.E. Smith, 1987). The ruling relations is one of the tenets of IE conceptualizations, significance of which in this study is prominent. The ruling relations are increasingly represented by textual forms of coordination through which power is embodied, transmitted, preserved, and (de)activated (D.E. Smith, 1987). D.E. Smith draws much of her ideas from a lifelong work of critiquing mainstream sociology by drawing insights from the teachings of Marx's materialism, Mead, Bakhtin and Volosinov philosophies, Foucault theories of power, and Garfinkel's Ethnomethodology (Devault & McCoy, 2006; Kearney et al., 2019; Joan Smith & Smith, 1992).

The goal of IE researchers is to learn how things work by studying the coordination of people's actual activities and explicating them (DeVault and McCoy, 2006). The inquiry always starts from the standpoint of people who are situated in the actualities of everyday life, allowing the researcher then to turn their gaze from the individual to the social (Deveau, 2008; Prodinger, Rudman, & Shaw, 2015; D. E. Smith, 1999). Several emerging scholars used IE to study a wide range of experiences from various standpoints of those with specific lived experiences. For example, Birgit Prodinger (2012) looked at the experiences of being an Austrian mother with rheumatoid arthritis (Prodinger, 2012). Also Alexis Buettgen's (2018) dissertation investigated, from the standpoint of persons with a disability, how the social organization of work in a non-profit sector shapes their experiences (Buettgen, 2018). Elizabeth Townsend explored the operation of the concept of empowerment in the practice of occupational therapists; and many more (Townsend, 1996, 1998). In my case, I took the standpoint of policymakers within defined

institutional sites where "policymaking" activities are concentrated and coordinated to shape the policies for the distribution of SDH to promote HE.

In this study, IE as a method of inquiry (Brown, 2006; Luken & Vaughan, 2003), is used for exploring social relations that structure policymakers' everyday lives; specifically by looking at ways that policymakers interact with each other in multiple socially organized settings and strive to expand the understanding of how these interactions are institutionalized (Campbell & Gregor, 2002; DE. Smith, 2005; Walby, 2013).

IE is not simply ethnography, but an ethnography of social relations that have been institutionalized (Tummons, 2017). The focus of IE is on how daily activities become a site of investigation of social organizations, that is, "the empirical investigation of linkages among local settings of everyday life, organizations, and trans-local processes of administrations and governance" (Devault & McCoy, 2006 p.751). The analytical fundamental to this approach is an ontology that views the social as the concerting of people's activities and reveals patterns of text-mediated relations organized around specific ruling functions such as policymaking (DeVault & McCoy, 2006).

It is worth clarifying the uniqueness of IE as compared to other qualitative research methods. IE rejects over-arching generalizations and theoretical constructs and keeps with the concern for everyday with a focus on the *local* (Tummons, 2017; DeVault & McCoy, 2006; Smith, 2005). That is, "where epistemology must also be the ontology – a way of thinking"(Prodinger & Turner, 2013, p.359). IE explores ways in which everyday work – defined as "anything that people do that requires effort, intent, and competence – is experienced, talked about, and made sense of by people at a local level" (D.E. Smith, 2006, p.10). D.E. Smith posits that the local is linked to translocal – those social, administrative, or geographical spaces that are outside the boundaries of

people's everyday life experiences but shape the understanding of the local through texts which may be paper-based, screen-based, words, images, notes and others (Campbell & Gregor, 2002; Campbell, 2014; D E Smith, 2005; Smith & Smith, 2006; Tummons, 2017). IE has four paradigmatic and conceptual frameworks relevant to this study: 1) the ruling relations; 2) the standpoint; 3) the problematic (DE. Smith, 1987, 2005, 2006; DeVault & McCoy, 2006; Rankin, 2017); and 4) conceptual practices of power (D.E. Smith, 1990). These concepts seek to foreground everyday knowledge and work of the people we set out to study (in my case, policymakers), allowing them to place their interpretations into focus by not objectifying them as mere participants (D E Smith, 1999, 2005, 2006; Tummon, 2017). In the next section, I briefly unpack IE's foundational concepts.

4.3 Taking a Standpoint

The standpoint is an empirical position where a group of people are positioned within a complex regime of institution and governance (D.E. Smith, 2005, 2006). The standpoint symbolizes the power of subjugation or subordination (D.E. Smith, 2005, 2006; Rankin, 2017). The undergirding principle here is that policymakers may exist in an institution where they do not exactly understand the process that shapes those spaces or are not necessarily aware of how these choices, preferences, and experiences are shaped by forms of knowledge and extant interests that are located outside the policymaker's routine, but from within the social structures that they are part of (DE. Smith 2005, 2006). To illustrate, Smith explains that by taking the women's standpoint in the everyday world of women's traditional work in their homes with their children meant beginning from where women are as bodies in the activities of their lives and exploring the society as it embeds, masters, organizes, shapes, and determines those activities as women live them (D.E.

Smith, 2006, p.3). This consciousness and the need to remain true to the founding value of IE requires that I use the pronoun "she" through this dissertation when referencing the standpoint participant's experiences. This is not being blind to the gendered implications of my choice, rather, it is befitting to honor IE traditions.

The researcher takes a standpoint to observe tension and contradictions that arise for those people being studied. The standpoint helps the researcher to discover how the participants come to know about how things work (D.E. Smith 2006; Rankin, 2017). The researcher uses the standpoint to relate both formal and informal activities at the site that contribute to something happening. The researcher goes further from where actual people are in their own lived experiences to open up relations and organizations in a sense present in them but not visible (D.E. Smith 2006).

As such, the IE research takes the standpoint of those with the experience to discover and make visible those social relations, so that from the participant's standpoint, we can see how things are coming about as they do (D.E. Smith 1987, 1999, 2006). Thus, the research uses the standpoint to build an account of how things that are happening are being organized and coordinated (Rankin, 2017; D.E. Smith, 1987). The standpoint is important because it allows the researcher to learn from the informant how their work is "ideologically" (through discursive, narratives) and "materially" (what people know about what goes on), and the knowledge is gained from doing the work (D.E. Smith, 1987, p. 82). Thus, the standpoint informant is considered an expert knower of the work processes, work activities, and everyday experiences accrued from the coordinated work. However, Smith cautions that the expert's knowledge cannot be valorized, made special, or even accepted as true, such that their knowledge is examined for its social construction and its contradictions (Rankin, 2017). The experiences of the standpoint informant may be analytical and empirical, however, what is considered as true is the material descriptions of things that happen,

that loosely agreed upon "world in common" (Rankin, 2017, p.2). Thus, to gain insight into the policymaking work on SDOH, I took an implicit standpoint of the policymakers as an entry point into the process of "discovering the social that does not subordinate the knowing subject to objectified forms of knowledge or political economy" (D.E. Smith, 2005, p.10). The standpoint was a "methodological device" (D.E. Smith, 2005, p. 206) that allowed me as a researcher to focus on the prospective, interests, and knowledge of participants as distinct from the overarching explanations of the researcher or perspectives from the social organization of other people who do not occupy the chosen standpoint.

4.4 Tracing the Ruling Relations

Ruling relations is a very important concept in policymaking studies. Relations of ruling and social relations are also important concepts within IE which denote practices that "activate" the social world of things happening among people (Rankin, 2017; D.E. Smith 1987, 1999, 2005, 2006). The ruling relations are social relations that organize the work from another site and are activated by people in the local setting, like the standpoint informants. Ruling relations influence how work at the standpoint is construed, organized, conducted and how that work is represented.

The ruling relations are increasingly enacted through the textual form of coordination that creates linkages between complex fields of coordination and represents the forms in which power is generated and held in society (D.E. Smith, 1999; DeVault & McCoy, 2006). Ruling relations coordinate what people come to know about what and when something is happening. In practice, the ruling relations are presented textually as a constellation of activities of power, governing work that depends on selecting, organizing, and/or objectifying aspects of the social worlds to develop facts or knowledge upon which to make decisions (Rankin, 2017; D.E. Smith, 2001a; J Smith &

Smith, 2006). According to D.E. Smith (2001a), the ruling relations embody the institutional order of society that excluded and silenced women and women's experiences. Smith further recognized that women's actualities of everyday/every-night world are organized extra-locally, abstracted, grounded in universalized forms, and objectified (D.E. Smith, 2001a). Thus, the term relations of ruling or ruling relations according to Smith (1999), designates the complex of extra-local relations that in contemporary societies provide a specialization of organization, control, and initiatives (Joan Smith & Smith, 2006).

D.E. Smith (1987) identifies these relations of ruling as bureaucracy, administration, management, professional organization, and the media that includes also discourses, scientific, technical, and cultural, that intersect, interpenetrate, and coordinate the multiple sites of the ruling relations. Ruling relations activate practices of knowledge that define how a problem comes to be known and experienced from the standpoint. The purpose of an IE researcher is therefore to find traces of the ruling relations within the description of everyday work – the occasions when work being done at the standpoint location no longer supports the interests and intents of the people there (Rankin, 2017).

4.5 Exploring the Problematic

One of the most important concepts in IE is the concept of the problematic with which, according to Smith (2006), the process of research starts. The problematic focuses on illuminating how people's everyday experience is hooked into and coordinated by the relations of ruling and may be part of what is happening now, to the researcher or to those whose standpoints interests the researcher to be empirically investigated. Once the researcher has unveiled the problem, she takes the standpoint of the informant with the experience (Campbell & Gregor, 2002). The purpose

of such an undertaking is to investigate the translocal ruling relations which affect the local experience of those whose standpoint the researcher has taken. (D. E. Smith 2005, 2006; Deveau, 2016; Rankin, 2017). DeVault and McCoy (2002) have posited that a problematic usually starts with an exploration of how the actualities of everyday lived experiences are hooked into, shaped by, and constituent of the institutional relations under explanation. The standpoint of the individual(s) whose experiences provide the starting place for the problematic under investigation is the most valuable in IE research (DeVault and McCoy, 2002). The researcher is expected to follow a three-step sequence that includes: 1) identifying an experience; 2) identifying some institutional processes (social relations) that are shaping the experience; and 3) investigating the process to describe analytically how they operate as the grounds for the experience.

4.6 Conceptual Practices of Power

D.E. Smith (1990) introduces the idea of conceptual practices of power to emphasize the materiality of ideology manifested in texts, and ruling relations resulting from ideological processes that guide the operations of the institution (D.E. Smith, 1990; Stanley, 2018). D.E. Smith (1990) observes that within these complex institutional work activities, what constitutes facts are analyzed as the result of institutionalized working practices. In understanding how ideology leads to objectification, D.E. Smith (1990) argues that the materiality of ideology is itself produced through a method that centers on canceling out the subject within an institutional apparatus that utilizes these objective approaches. Thus, the objectification of knowledge produces factual accounts of different kinds of knowledge functioning as records, statistics, news, data, databases, files, and others that are transmitted textually. Through texts, the conceptual practices of power can conceal the ruling relations within the complex workings of the organization. Focusing on

conceptual practices of power as an IE concept is particularly important in highlighting the role of power, its influences, and other influences in the policymaking process such as the role of corporations, labour movements, civil society organizations, and political activity.

4.7 Identifying the Standpoint Participants

The definition of 'policymaking as work' and 'policymakers' as institutional actors can be contested as many actors within policymaking institutions perform different roles such that authorization of an official policy outcome may not be attributed to an individual (K.E. Smith & Katikireddi, 2013). Scholars investigating policymaking have developed a list of the people they believe that in one way or another contribute to the policymaking process and therefore qualify as policymakers. Such a list includes current or former government ministers, senior federal, provincial, and municipal policy advisers, lobbyists, and senior policy researchers, technical persons, consultants, corporate and Civil Society Organization leaders, among others. (Brownson et al., 2006; Carey & Crammond, 2015; Ellen et al., 2016; K. A. Oliver et al., 2017).

For this study, I modified and extended this definition of policymakers to include Municipal Medical Officers of Health and members of Boards of Health who work in public health units on health-related public policy. Furthermore, certain actors outside the institution of government, such as civil society organization executives and issues-area experts/consultants and researchers have also been included in this study as standpoint participants. In IE, policymaking is work because anything that people do that requires effort, intent, and competence – is experienced, talked about, and made sense of by people at a local level – constitutes work (Smith, 1987, 2006, 2005).

In IE, the definition of work can be quite elaborate (DeVault & McCoy, 2006). Additionally, studies that focus on ruling relations and institutional processes also reveal sequences of inter-connected activities between policymakers. These sequences are usually text-mediated and are identifiable for analysis. Thus, talking with people through interviews reveal how social relations and everyday activities are coordinated in these multiple sites (Devault & McCoy, 2006). D.E. Smith (1987) emphasized that IE begins with the identification of an experience or area of everyday practices that are taken as the experience whose determinants are to be explored. Policymakers enact public policy which may be identified by policy instruments such as laws, guidelines, regulations, protocols, or criteria that affect the distribution of SDH (Brownson et al, 2006)

Thus, taking the standpoint of policymakers, I attempt to explicate the everyday work experiences from the standpoint of policymakers within a health institution by exploring these areas of entry:

a) What constitutes policymaking as work? What exactly do the participants who identify themselves as policymakers and have policymaking experience do as part of their everyday activities that contribute to HE considerations?
b) Are these policymakers aware of other related influences during their work activities that shape their decision-making processes?
c) Are policymakers aware of the health impact of the policies they make on the population that they target?
d) How do institutional rules, cultures, and values shape the understanding of work and choices of work activities on HE considerations for the distribution of SDH? This question

usually elicited references to texts, whether current, active, or now obsolete, and institutional expectations, hegemonic cultures – now taken for granted.

4.8 Data Collection Process

IE study relies on three sources of data: 1) interviews of standpoint participants; 2) text or documents that coordinate participant's work within the social organization and reveal the relations of ruling; and 3) observation of how the work processes being investigated are articulated or narrated (D.E. Smith, 2005, 2006; DeVault & McCoy, 2006; Rankin, 2017). From these three processes, data is gathered to guide the researcher in discovering what policymakers working on an issue such as HE considerations, actually do and how the institution in which they work mediate key concepts such as HE/SDH in the policymaking activities, thereby augmenting our understanding of "how it happens" or "do not happen" (DeVault & McCoy, 2006a p. 755) and thereby illuminating "how things work" (DeVault &McCoy, 2006b, p.23).

Campbell and Gregor (2002) identify two levels of data collection. The first is entry-level data gathered from the interactions and activities of the informants whose experience is being studied in the local setting. This data set shapes the selection of the second level gathered from those positioned outside the setting. As such, the participants' selection in IE privileges a purposive or snowballing sampling method (DeVault & McCoy, 2006).

4.9 Recruiting the Standpoint Participants

In IE, sampling is geared towards accessing institutional processes as opposed to the concern of other research methods that seek representative samples (Rankin, 2018). As part of the research proposal, the study prepared a list of initial potential standpoint participants who met the criteria of having worked or are still working as a policymaker as defined earlier (see description of the standpoint participants on p.38). As the principal investigator, I identified government agencies and organizations that could provide rich data for the concepts under investigation within which individuals' work experiences could be studied. At the federal level, I chose participants within the Public Health Agency of Canada (PHAC) and recruited the first standpoint participant by first sending an email explaining the purpose of making contact. When the standpoint participant demonstrated interest in her reply, I provided the approved research package containing the following: a) official request to interview letter; b) study information summary; and c) an informed consent letter with instructions for the potential standpoint participant. They then responded by agreeing to audio recording and returning the signed consent form (see these in the appendix). Once I received the informed consent form, I scheduled a one-hour interview.

Before interviewing the standpoint participant, I prepared myself well by taking time to learn about their organization and its work. After interviewing the standpoint participant(s), I requested that they recommend another person from their institution or policymaking circle, essentially implementing a snowballing recruitment method.

I found the snowballing method to be effective in recruiting standpoint participants from different institutional positions of experience and different levels within the institutional bureaucratic hierarchies and with a wide range of institutional work experiences spanning decades. I agreed with IE scholars that each interview became an opportunity to learn about other extended

relational chains within the organizations that opened new exploratory horizons (DeVault &McCoy, 2006).

Unfortunately, I could not speak directly with a standpoint participant from the Ontario Ministry of Health or the arms-length Public Health Ontario agency, as all declined to speak with me. In areas where I did not have direct connections, I did some background reading about numerous organizations with recognized roles and experiences in shaping HE/SDH discourses. I then emailed executives/directors of these civil society organizations and research institutes. I also reached out to former government employees and retired officials and former policymakers who had moved on to other work.

This way, I recruited 24 participants from a diverse and rich standpoint experience of policymaking from three provinces: Ontario, Saskatchewan, and British Columbia. My data was able to capture work experiences that panned over three decades, and provided depth and an overview of trends in HE policy work in Canada. The section below provides context to the data collected from the three levels of government in Canada.

4.9.1 Federal Level Data sources

I recruited nine standpoint participants at the federal level. These participants had either current jobs with a policymaking role or former employees with similar roles who were either retired or moved on to other roles outside the government institution. The breakdown of the nine participants is as follows: three current office holders who identified their work as "making policies, implementing health interventions, testing and evaluating policies, overseeing and evaluating health programs and innovations to promote HE"; four former high-ranking federal health officials who held various privileged positions within the institution that made health

policies; and two senior officials at the National Collaborating Centre for the Determinants of Health (NCCDH) charged with promoting HE activities across Canada.

4.9.2 Provincial Level Data Sources

At the provincial level, I recruited four standpoint participants. One was an elected official currently holding a position described as "policymaking with a focus on HE", one standpoint participant had a career at the level of deputy Minister of Health. I recruited two executive directors from civil society agencies who described their roles, activities, interests, and goals as "influencing the provincial policymaking towards HE policy considerations for the distribution of SDH". Below I provide a table of standpoint participants from the three levels of government who participated in my study.

Table 4. 1 A summary of standpoint participants by level of government

Level of Government	Number of Participants	Description of Standpoint of Participant	Location of Participant(s)
Federal Level	9	2 Policy Analysts 1 Manager 3 Former Health/PHAC officials 2 Directors from other agencies working directly with PHAC funded	Participants had a working knowledge of HE work in Ontario, Saskatchewan, and British Columbia
Province	4	1 Elected Member of Provincial Parliament 1 Former Provincial Minister 1 Director of a think tank 1 Director of a health policy advocacy group	Recruited from Ontario, Saskatchewan, and British Columbia
Municipality	11	2 Board of Health Members from two PHUs	Both BOH in Ontario
		2 Medical Officers from two PHU in Ontario	One MOH had an urban PHU and the other had an urban and rural PHU

		3 Members of Senior Management Team of a PHU	Average of 30 years of experience per participant
		4 Healthy Public Policy officials from two PHUs	Participants were drawn from Ontario

4.9.3 Municipal Level Data Sources

At the municipal level, I recruited 11 participants from Ontario Public Health Units (PHU). Two were members of a Board of Health; two were Medical Officers of Health (MOH) with one from an urban PHU and another from an urban PHU with a largely rural community; three at the senior management level, i.e., directors and program managers of a PHU, each having over 30 years of work experience; and four health promotion specialists working directly in various PHU healthy public policy portfolios with work experience of 4 -11 years in this position.

4.10 Talking with participants vs. Interviewing Participants

IE projects recommends that researchers develop the capacity to talk with standpoint participants as a distinguishing characteristic of this method of inquiry. McVault and McCoy (2006) posit that what IE researchers do can best be described as talking with people. This is also the position I pursued. To prepare for talking with standpoint participants, I developed an open-ended script that allowed for an open-ended inquiry into these issues.

Interviews were scheduled for one hour; however, each interview took from 60 – 80 minutes. The interviews were audio-recorded following a signed consent from each participant. All interviews were later transcribed and organized in an excel spreadsheet for analysis.

4.10.1 Earliest Data Collection - Interviews

I conducted in-person interviews with the first four standpoint participants from the municipal level in a quiet office that provided confidentiality. The standpoint informant booked the office or computer rooms in their office building where it took place. The coronavirus pandemic disrupted my face-to-face data collection. This did not allow me to continue using IE observation moments as a source of data. The Observation allowed for assessing disjuncture or the problematic in their everyday work experiences. These are moments when nonverbal cues identified issues that required further probing when the opportunity presented itself.

When the standpoint participants described what they do, their work knowledge became an empirical resource (Zurawski, 2012). It revealed how the policymaking activities, processes, and decisions come about, and how these activities are socially organized and coordinated by text and institutional discourses. These directed me to gather relevant texts/documents and identify areas of inquiry with the next participant (Ng et al., 2013). These participants provided leads to how local activities were coordinated and hooked onto the work of others in multiple sites. Those rich descriptions shaped my selection of the next participant and the gathering of additional.

At times, the person I *talked with* was kind enough to provide me with connections to the next participant. Others offered to recruit the next participant with the standpoint experience of interest. Once I made those connections with these potential participants, I secured their email

contacts and dispatched the study instrument, describing my study, its techniques, purpose, and potential risk, and requested for an audio-recorded interview.

4.10.2 The Pandemic Disruptions in Data Collection

It is important to note that when the coronavirus pandemic arose, it became impossible to continue using in-person methods. The pandemic required a switch to over-the-phone interviewing which removed the gathering data based on observation of the standpoint participants' interactive language during the interviews. Eventually, York University developed a policy that enabled us to interview over video applications such as Zoom, Google Meet, and other secure video platforms.

On October 6, 2020, York University's Research Ethics Review Coordinator sent an email recognizing the impact of March 23, 2020 pandemic lockdown in Canada (and the world) on research and data gathering generally for its students and staff. In the email, I was advised that face-to-face interviews were banned due to the requirements of pandemic prevention measures. I was invited to apply to amend my ethics requirements to accommodate the use of the Zoom application and the amendment was granted on November 27, 2020. Before that point of adopting the video interface, I had conducted a few interviews over the phone. The option of an over-the-phone interview was accounted for in the initial research protocol intended for long-distance participants in other provinces. I used the York University staff licensed Zoom interphase for additional three interviews. It allowed me a true IE moment of talking with standpoint participants where I could observe a full dialogue of conflicts, contradictions, excitement, triumph, resistance, surprises, and consciousness awakening among my participants.

4.11 Identifying Texts/Documents (See a list of documents in appendix)

Before talking with standpoint participants, I performed due diligence by checking their roles and job description – the standpoint experience of interest for which I would interrogate them. I searched the internet to gather information about the institution in which health policy is made and whose standpoint participants I would interview. I searched for what the institution does, its history, management, structure, reports, and the roles of the individuals I would interview.

I also searched for relevant high-order documents (Stanley, 2018) such as standards, directives, department plans, reports as well as related academic literature concerning the participant's institution or department. I gathered accessible documents that linked to participants' work, such as contracts, protocols, union status, and assignment briefs. I searched for links of the work of a participant to the work of others. Traces of social organizing and relations of the ruling have increasingly become textual, and access to which has become easier with the advent of communications technology. In doing this pre-interview study, I was careful not to be intrusive. Rather, my goal was to gather sufficient relevant information to enrich my talking with the participants and constructively engage with them in meaningful dialogues. Indeed, I found that speaking from an informed point of view elicited more conversation and expanded the horizon for exploration.

Texts are fundamental when using IE as a method of study. In institutional ethnography, texts are any written or graphic materials that are reproducible and used in coordinating translocal activities (D.E. Smith, 1987, 1990, 2005, 2006). Texts produced in one place are influential in coordinating activities and knowledge in different institutional sites (Rudrum, 2016). In gathering and analyzing texts, the IE researcher becomes sensitive to the fact that texts are the strings that tie together actions in both the local contexts and the broader or extra-local contexts (Rudrum, 2013). D.E. Smith (1990) cautions IE users to recognize that texts are the most active and dominant

constituent of institutional processes. Texts reveal how activities within an actual setting extend beyond the local and provide for the standardized recognizability of people's doings as organizational or institutional (D.E. Smith 2001, 2006; Turner 2006; Prodinger &Turner, 2013). The purpose of identifying and analyzing institutional texts is to guide us in mapping out institutional processes that determine people's sequence of actions within the institutions.

For Turner (2006), texts reveal governing and policy work as they put policy into action to produce what happens as routine (p.140). Furthermore, texts generate replicable forms of social action that shape people's actualities where these texts come together when activated becoming the acts of the institution (Turner, 2006). According to D.E. Smith (1990), texts as constituents of social relations offer access to the ontological ground of institutional processes which organize, govern, and regulate the kind of society in which we live (p. 122). Additionally, texts determine the social actions that shape bureaucracy, professional and scientific discourses, objective forms of management which depend increasingly on textual forms of communication. The enumerated functions of texts, thus make text identification, gathering, and analysis an important component of IE research.

As I talked with the participants, I paid close attention to references to ruling relations, and social organizing of work. I heeded Campbell and Gregor (2008) who cautioned that we do not look for the social organization of work, rather we use its mention or materiality to interrogate for the relations of ruling. While talking with participants, I was able to catch references to text or text-mediated processes that directed their everyday work, influenced their decisions, described their role fulfillment and those institutional practices that they felt were disempowering, needed overriding, were burdensome, or empowering/elevating. D.E. Smith states that during interviews, texts or documents may be mentioned in passing (not focal) or mentioned without actually naming

it (D.E. Smith 2005). As an IE researcher who is conscious of policy work being a high text producing and textually coordinated work, I took note of all referenced texts, probing about and for them, and asked to be provided with or guided to them as data for analysis. I made it known to the participants that text-related materials are an important part of the data.

In IE, texts can have specific characteristics: a) coordination of social activities in sequences of actions that link the action of one individual to others (Ng, et al., 2013); b) embodies the institutional authorities from various levels of government – federal, provincial and municipal; c) conveys institutional norms, rules, conventions, habits and values; and d) explicitly or implicitly allude to extra-local links such as business/corporate sector influences and interests (Campbell, 2014; D. E. Smith, 2001; D.E. Smith, 1990). Texts influence the social organization of social relations around SDH and HE by coordinating policymakers' actions. In most cases, participants provided references to relevant texts and in some instances gathered and sent them to me. A few standpoint participants referred me to their institutional websites. I gathered numerous texts that became instrumental in making sense of what policymakers do within the multiple sites of interest to this study and in their consideration of HE concepts and their impact on the equitable distribution of SDH.

4.12 Observation and Field Notes

While observation forms part of the active process of talking with standpoint participants, that could have allowed me to witness what they say and how they say it, as well as detecting moments of disjuncture when confronting the problematic. I have stated that observation was not possible for most of my talking activities due to the pandemic lockdown and its physical/social distancing measures. As such, I missed the details of body language, vocal intonations, facial

expressions, mood ranges and temperaments, laughter or moments of tension, joy, and ease during the interview, all of which could have helped reveal moments of disjuncture with the participants (Rakin, 2017; DeVault & McCoy, 2006). Moreover, DeVault and McCoy (2006), revealed that active observation could earmark points for further exploration into activities of social relations within policymaking. I concede that I had limited opportunities for IE moments of observations. Neonetheless, the few observations that I made and the field notes from those initial interviews, greatly enriched my analytical work.

4.13 Establishing the Problematic

In IE, when the researcher situates himself at the policymaker's standpoint, the problematic is expected to arise through identifying experiences of frustrations and mystification or a disjuncture to reveal the problematic (Ng et al., 2013). A problematic is not the study problem or research problem statement, rather, the moments of contradictions experienced by the standpoint participants. Capturing moments when I realized that a participant was conflicted allowed me to explore meanings associated with their verbally undescribed experiences and the implication on the policymaking as work being done either at the site (local) or trans-locally. The problematic entails how the policymaker talks with the researcher while illuminating his/her everyday experiences as hooked into and coordinated by the ruling relations (D.E. Smith 2005, 2006). The problematic comprises malingering and latent questions lacking explanation from those whose experiences are shaped by the problematic (D.E. Smith, 2005). In IE, the problematic offers opportunities to explore the local context of this moment through further probing to reveal a pattern of work processes that produce, reproduce or sustain this problematic. The work process becomes the center of exploration to identify how this individual is hooked onto the ruling process (Ng et

al., 2013). Indeed, as DeVault and McCoy (2006) stated, the policymaker's experiences provided me with clues about the work organization and a starting point for mapping out relations of policymaking in different settings. Thus, being aware of the problematic and taking notes of those moments during the data collection and noting them into a separate entry during data analysis opened doors for an elaborate in-depth exploration of contradictory concepts and activities, as well as decisions of standpoint participants as shall be captured in the findings of this study.

4.14 Data Analysis

There is no one gold standard or preferred recommended approach to data analysis in IE. Scholars conducting data analysis in IE are aware that IE analysis frequently follows traditional social sciences qualitative data analysis as seen in ethnographic studies. Campbell and Gregor (2008) suggest that the main analytical notion when conducting data analysis in IE is the idea of social relations. Further, the IE researcher understands that this data was derived from worksites and therefore, "the meaning of the data is in their settings of use as they arise there" (Campbell & Gregor, 2008, p.85). This awareness I carried along while analyzing the data enabled me to remain factual to the actualities of the standpoint participants.

In approaching my data analysis, I did not come with a blank mind. I had gathered field notes, institutional texts, and talked with participants, transcribing their data, and cross-referencing accounts or narratives from these materials. I reflected deeply on my research journey during the process of data collection and reading various Ph.D. theses that used IE to gain insights into how these researchers analyzed their data. Rankin (2017) advised that this endeavour must be undertaken as a "social organization of knowledge" that prepares the researcher's critical position

on issues of interest (p.5). Again, the key element in IE data analysis is to explicate the social relations in ways that make sense locally and trans-locally (Campbell & Greagor, 2008).

Once my data was transcribed, cleaned, and arranged carefully in five excel sheets by the levels of government (data from the federal level that included interview scripts, texts and fieldnotes were organized in a file labeled federal level and so were data from provincial and municipal – Board of Health and PHU). The initial analysis started from reading federal data where the initial data analysis led to discoveries and gathering of more texts, emails, online resources, and making notes on their relevance as well as contents. The first reading allowed me to gauge the potential of the data in describing the social organization of work, work relations, what happens and how it happens, and who the key players are. As I read the interview transcripts over and over, it allowed me to begin narrowing down the relevant texts that align with certain aspects of social relations and work organization that jumped at me.

I looked for descriptions of certain actions, the mention of institutional "ways of doing things" or "how things are done", obstacles, contradictions/disjuncture, and levers for change. I recorded those and colour-coded them. I searched the data in ways that it started communicating back to me and guiding me to what it was revealing – making visible the relations of ruling, other connecting subordinate texts, and the problematic. I noted each of those in different folders and continued to cross-reference and sift through my text and field notes.

Before the second reading, I reviewed my notes from the first reading and compared findings with field notes from the interviews, and notes from preparatory readings of the literature. This exercise afforded me a general sense of what was happening in PHAC as an institution and how it was happening elsewhere at the provincial and municipal government levels. In the second reading, I embarked on mapping out how policymaking as work was defined, understood,

described, and coordinated from the standpoint of the policymakers. I cross-referenced these discoveries with texts, as the texts are privileged or recognized in the interview. Through the second reading, I mapped the text-mediated relations of ruling and sorted out texts and the text sequence through which social relations became apparent.

As I proceeded with data analysis, I surrendered to the data so it could lead me, and I followed the emerging patterns from the texts that jumped at me. I traced the texts that socially organize policymaking in these institutions from the highest level of Prime Minister to the lowest level of policymaker at the centres or divisions within the PHAC structures. I extracted the texts and made them available for critical discourse analysis (Fairclough, 2013; Peacock, 2017). I continued making side notes and used colour codes to identify passages that jumped at me due to its clarity and linkages to the documents and accounts from my first reading – accounts and narratives that described the social organization, local and translocal coordination of work, ruling relations, conceptual practices within institutional sites, and the social relations in policymaking processes as work. I picked accounts that detailed work relations, descriptions of power/authority, a measure of progress, obstacles, prospects, tensions, resistances, pessimism, ambiguities, and levers of change, as well as external influences.

In the third reading, I focused on institutional structures in which internal hierarchies and bureaucracies come to bear through conceptual practices and that which influences the social organization of work. I kept detailed notes of this analytical process. I then focused my attention on understanding how policymaking as work was mobilized and organized within specific settings where the standpoint participants worked every day. This focused gaze allowed me to further decipher and zero down on the governing or authoritative texts that organize these site work. This inquiry led me to begin connecting the work done as policymaking work, to be able to describe it,

and then connect it to the ruling relations and the works of others being done in distant sites such as the health equity work being done in communities, and in National Collaborating Centres for Determinants of Health.

To provide structure to my analytical work, I asked myself several questions, such as "What constitutes policymaking as work?" and, "What exactly do the participants who identify themselves as policymakers and have policymaking experience do?". Moreover, I was curious to know what policymakers do as part of their everyday activities that contribute to making policies with HE considerations. I then searched the data to confirm whether these policymakers offered accounts that show they are aware of their actual everyday activities as coordinated work and what control they had over their health equity policymaking as work. I then took excerpts and colour coded them. My next step was to explore whether policymakers' accounts linked their work to external influences that bear upon their work activities – the work that shapes their decision-making processes.

As I probed the data further, I looked for whether the standpoint participants were actually aware or informed of the impacts of the health policies they make. I took notes of these accounts, highlighting conflicts/contradictions, and extracted excerpts as evidence. In undertaking all these steps, I remained committed to the data as my companion. In the subsequent layer of my analysis, I turned my interrogation of data to institutional rules – explicit or implicit, cultures, traditions, and rituals, and values that shape policymakers' understanding of their work and choices of their work activities on HE and SDH. Prodinger and Turner (2013) found this question usually elicited references to "active texts that participants engaged with and that were of concern to them" (p.361).

In conducting my data analysis, I read several other doctoral theses and found useful guidance in Cheryl Zuraski's (2012) dissertation that focused on work and work-related learning

of employees in certain organizations (Zuraski, 2012). Zuraski (2012) herself anchored much of her data analytical processes on the works of Birgit Townsend (1996, 1998) on the operationalization of the concept of empowerment in the practice of occupational therapists.

After I picked out the two theses, I realized that both Townsend's and Zuraski's analytical work were not far from my own and could help guide me from the murkiness of overwhelming data. Having read Prodinger and Turner's (2013) work that explored how social policies infiltrate into daily life, I was confident my data analysis was on the right track. Additionally, I took guidance from Campbell and Gregor's (2013) work which directed me to the main task of discovering the working of society and ruling relations in everyday life, and how these everyday activities are being coordinated at PHAC and other policymaking sites in the lower levels of government. Reading Campbell and Gregor (2013) as well as Rankin (2017) steered me to the IE mission of describing how the ruling and social relations coordinate what people in the standpoint situation know and do. Interestingly, Zuraski (2012) described an in-depth data analysis that involved immersion and crystallization (Borkan, 1999) and using writing – including memo-writing (Charmaz, 2006), as methods of inquiry into the data. I found some of these concepts to correspond with my experiences with data analysis. I realized that as I got deeper in probing my data, I became more engaged intuitively; and for the most part, I was able to connect various concepts to the social organization of policymaking as work.

Once I brought order to my data, I pulled together themes, descriptions, expressions, and metaphors that alluded to the accounts of how things in the institution worked. I was able to describe the kind of work that policymakers do and how that work was socially organized and then coordinated with the work of others through texts. This account included making the relations of ruling visible within an institutional bureaucratic structure in which policymaking occurs. The

process of analysis opened my eyes to external forces whose influences may be visible or concealed but continue to influence what happens at the policymaking sites remotely.

4.15 Critical Analysis of Texts

I then turned my analytical gaze to the texts without which the accounts of the standpoint participants would be incomplete, and a description of ruling relations would be impossible. Campbell and Gregor (2013) acknowledge that "text appears in people's talk because they are integral to what people do and know" (p.79). I sorted all the texts and assembled them in order of their authority while sorting out texts in order of their relevance at different institutional sites. I had a large binder of printed texts and a file folder on my computer for downloaded texts. I arranged documents in their order of influence as identified by the standpoint participants. Bisaillon, (2012) describes the boss texts and subordinate texts, while Stanley (2018) identifies the higher-order texts as dominating social organization, especially for a highly bureaucratic institutional setting such as the one under my study.

I selected documents that were authoritative and governing to analyze for their implications from point of origin to the local sites where they were to be activated into actions. Once I laid down the documents from the highest order to that which is produced or subordinated hierarchically, I began reading the texts as I did read the interview data. First, I was interested in the coded messages they carried – paying attention to language, narratives, patterns, and the potential impacts, agenda, ideology, traditions that they conveyed. I then searched for connections between concepts or ideas in these texts for implications once activated at local sites where they were meant to be activated. The second interest was the force that the articles or passages carried and their organizing abilities on institutional sites if they complimented or overrode (controlling

thrust) other existing authoritative texts and actions. I then analyzed the language in the text for HE/SDH concepts specifically, interrogating the texts for implicit or explicit recognition of, and describing HE for action on SDH. My goal was to identify instances where explicit or implicit actions on HE/SDH concepts were prescribed, or responsibility for these actions were assigned to an institutional actor with a clear mandate and accountability requirements. I then looked up the job description and mandate of these actors together with some of their outputs (reports, notes, policy recommendations, description of interests, qualifications, and years of experience in the position or institution) from texts and institutional web pages.

I then used my experience to sort out the key authoritative institutional texts to reduce the volume of texts I had gathered. I returned to the authoritative texts and scanned them for visibility of HE/SDH concepts, e.g., whether these concepts were mentioned explicitly or implicitly in the directives, articles, and clauses or whether or not the concepts were implied when not directly mentioned. I also asked questions like what other dominant contending or complimenting narratives, or principles were explicit or implicit in these documents and who was responsible for promoting them. I further interested myself in understanding whether there was uniformity in language describing HE/SDH and their urgency for health policy. I took my notes and mapped out these documents into a schema that I will present in the discoveries section.

The text analysis provided a map of what constituted health policy making with a focus on HE and how this work was socially organized and allowed the explication of the actualities in my analytical reporting in ways that remained true to the descriptions of the relations of ruling, the problematic, conceptual practices within these institutions and social organization of policymaking as work.

In sum, the analytical work undertaken was laborious, rigorous, and as true as possible to the data. Overall, the process I went through in my data analysis mirrors the order described by Rankin, (2017), i.e.: a) discovering the latent; b) identifying tension and contradictions; c) identifying the ruling relations; d) mapping, indexing; d) a critical discourse analysis on reports, documents, and other text materials gathered; and e) writing the accounts (Rankin, 2017). I repeated this process of analysis systematically for data from all levels of government.

4.16 Writing the Discoveries

Writing the discoveries was the most challenging task due to the demand for clarity. Campbell and Gregor (2008) guide that IE accounts ought to be compellingly convincing in how it is reported to make sense to the reader. In writing my discoveries, I focused on explicating the social relations, and the relations of ruling by making the connections between the work of policymaking and the forms of ruling and governance therein. I mapped these relations and drew diagrams to enhance the clarity of my presentation where my writing might have been insufficient.

First, I described the institution and identified texts and textually-mediated relations of ruling, mapping these out from top to bottom. I analytically described the work that was being done and how it was being done with different actors in different locations. Once I was convinced that I had the full account of what the institution was all about and how the work in it was socially organized, I described the sequences of work that constitute policymaking. I then provided an account of how HE and SDH were made implicit or explicit in texts and attempted to identify locations where these concepts were often concealed, subordinated, or obliterated from the institutional texts, discursive, narratives, and discourses. I then present the working experiences of

the standpoint participants with HE/SDH, how this work was coordinated locally and extra-locally. I presented accounts of problematic and disjuncture and then wrote up institutional conceptual practices – tradition, values, rules, practices, routines, beliefs, and norms – that make promoting HE policymaking on SDH possible or that which resists it. By studying PHAC as a federal level institution of health equity policymaking, by no means did I assume that it was the only organization where health equity policies were influenced, nor did I assume that policymakers' practices and experiences at all federal level institutions where health equity concept was promoted were the same. The same stance remained for my studying of provincial and municipal level policymaking events. I then drew my conclusions and accepted that others should have the opportunity to review my original work with an open mind.

4.17 Producing Faithful Accounts

In an earlier section, I laid out the distinction between IE and other forms of qualitative studies and ethnographies (See section 4.13). These studies are more concerned about issues of validity, transferability, generalizability, triangulation, and reliability among others (LeCompte & Goetz, 2016). In this IE study, my analytical approaches focused on explicating how the work experiences and work knowledge of policymakers in various public institutions are socially organized. D.E. Smith (2005) describes work knowledge as a person's experience of what they do, how they do it, including how they think and feel about their work. D.E. Smith further posit that the work experience is only relevant if we know the explicit or implicit coordination of that work with the work of others. All my explication resulted from my analysis of interview transcripts, observational field notes, and text analysis. Thus, this write-up is a faithful account.

I strove to remain faithful to the accounts of the actualities of my standpoint participants' everyday work experiences as they narrated it to me through dialogue (D.E. Smith, 2005). In IE concerns about triangulation, member checking, validity, and reliability do not arise on three accounts: a) the data collected and analyzed does not attempt to make sense of inner experiences or subjective states of mind for reframing a factual or essential description of policymaker's experience (See: Zurawski, 2012; Campbell, 1998); b) data analysis process traces and analytically describes the connection between work organized by ruling relations that shape local experiences and organize particular social phenomena such as policymaking as work (Zurawski, 2012); and c) IE strives to use data to reveal what is going on and map out the social organization of work knowledge and not intrude into personal lives and reveal wrong doings of others (D.E. Smith, 2005; Zurarski, 2012).

It is important to acknowledge here that IE is more concerned with what D.E. Smith called "institutional capture" (p.155). Institutional capture is where institutional discourses enter into and distort the dialogue that produces work knowledge. The researcher is set against the "capacity of the institution" where they subsume or displace work descriptions based on experience (p. 155). D.E. Smith is cautious especially when the researcher and informants are both familiar with the institutional discourses. According to D.E. Smith (2005), once dialogue goes into this phase, it means that "the informant's accounts is in institutional terms and is descriptively empty" (p.156). Norstedt and Breimo (2016) informs IE researchers that in order to escape institution capture, the researcher has to be cautious of the kind of question asked about how things work, and accounts of how texts are activated through work practices.

As a researcher, I went into the data collection phase with much consciousness of what is required of me, especially as an IE researcher. I have worked in public health for over a decade

and the risk of institutional capture was high. However, this risk would not have been as high as that which could confront a researcher with little or no work experience in public health, or with little or no preparation in IE. To avoid institutional capture, I did not reveal my work, profession, or practices to the standpoint participants. This decision ensured that the standpoint participant did not suspect, expect, or assume that I understood institutional discourses such that they could use institutional language, slang, and lexicons when answering to my questions. I was able to dialogue and explore concepts within the institutional discourses like a curious outsider with a blank mind. I was successful in discouraging the use of technical institutional jargons by constantly probing or requesting standpoint participants for everyday meanings when such came up. I could pick traces of surprises in the tones of the standpoint participants or pauses as they became conscious of the use of language.

4.18 Study's Ethics

This study received full research ethics approval from York University on two occasions. The first research ethics approval was issued in October of 2019 before the pandemic. This clearance supported a research design that was planned to incorporate the three methods of data collection in Institutional Ethnography, namely: face-to-face interviews, observation, and text gathering. The pandemic made it impossible to conduct in-person interviews necessitating creativity and exploring other modes of data collection such as telephone interviews or over video platforms. York University invited the PI to reapply and account for how the new modes of data collection would meet and maintain a high ethical standard and my application was approved.

Chapter 5: The Discoveries

In this chapter, I present discoveries from three analytical activities: institutional analysis of PHAC, analysis of text and text-mediated relations of ruling that govern policymaking as work within PHAC, and the social organization of policymaking as work. I then present institutional conceptual practices where I map out institutional conceptualizations of HE policymaking as work and SDH through texts. I draw insights from the standpoint participants' everyday work experiences from interview data to make visible the influences of the institution on health policymaking as work and the perception of policymakers as institutional actors on promoting health equity through policies for actions on SDH. The purpose of this section is to demonstrate where HE/SDH concepts become explicitly (made present deliberately) or concealed (undermined). Furthermore, this section illuminates how and by whom HE/SDH concepts are negotiated or resisted in institutional texts, practices, and discourses.

PHAC was chosen as an institution of choice because it is a primary institutional site of health policymaking in Canada's health portfolio with a national presence and influence over the health of Canadians. Additionally, the Chief Public Health Officer is expected to coordinate, advocate and facilitate communication between provincial, regional and local levels where public health policies and programs are developed and implemented in tandem with the constitutional divisions of powers and evolution of public health in Canada (Farfard & Forest, 2018). Provinces, regions and local level authorities benefit from evidence, standards and resources for HE policymaking from the federal government through efforts built from federally funded agencies such as the National Collaborating Centres, the Pan–Canadian Public Health Networks, Canadian Public Health Association, et cetera. Therefore, situating the study in PHAC was not to disregard the constitutionally mandated role of provinces, regions and local municipal in health

policymaking given their mandates, rather these efforts are considered separately in chapter 6, followed by the role of municipalities discussed in chapters 7 and 8. This chapter also attempts to illuminate the influences of external forces on health equity discourse, such as corporate/business sector players, civil society organizations, labour movements, and political ideologies.

The reader is alerted to the fact that for this dissertation, much detailed analysis of policymaking activities within an institution is provided for the federal sites with less at the provincial and municipal levels. Furthermore, the reader is alerted to the lengthy critical discourse analysis afforded the health mandate letter which the Prime Minister provided to the Minister of Health on December 13, 2019, and the supplementary mandate letter issued on January 15, 2021. Precisely, the Health Minister's mandate letter is the higher-order text that embodies the relations of ruling – an all-encompassing document that sets the tone for the social organization of health equity policymaking for actions on SDH in Canada, thus, the attention afforded this section.

5.1 Introduction to Canada's Public Health Portfolio

Studies that are focused on health institutions offer insights into the making of HE-related public policy for promoting the quality and equitable distribution of the SDH (Raphael, 20016; 2015). By mapping out the institutional structures and identifying the constellation of coordinated policy work and activities across sites. I intend to make visible the ruling relations and social organization of policymaking. The discoveries are rooted in the analysis of text-based and text-mediated social relations that shape the HE/SDH policymaking process. I further mapped out the institutional conceptual practices from the local to intra- and extra-local coordination of HE/SDH concepts in policymaking as work. My gaze turned to locations and activities where HE/SDH concepts are made visible, resisted, suppressed, subordinated, or concealed. These discoveries may

offer partial explanations as to why the concerted work activities that should promote HE for actions on the SDH are not filtering into health policy (Mcintyre et al., 2013). First, I presented the institutions in Canada that may have the mandate to develop health policy and then focused on PHAC as a specific institutional site of analysis of my analytical work.

In Canada, the responsibility of maintaining and improving public health is the mandate of the Federal Minister of Health. The Minister of Health presides over what is called the Health's Portfolio consisting of five agencies: a) Health Canada; b) the Public Health Agency of Canada (PHAC); c) the Canadian Institutes of Health Research; d) the Patented Medicines Prices Review Board; and e) the Canadian Food Inspection Agency (Government of Canada, 2017)[4]

The Health Portfolio consists of approximately 12,000 full-time equivalent employees with an annual budget estimated to be over $3.8 billion in 2020 (Government of Canada, 2020). The Minister of Health is accountable to Parliament for administering over 20 health-related laws and associated regulations that govern the overall programs and policies (Shah, 2003). The Minister is aided by a Deputy Minister and an Associate Deputy Minister of Health (as of 2021, the latter two are medical doctors) who manage the various branches and departments within the Health Portfolio. There are also several Assistant Deputy Ministers and regional directors who manage the everyday operations of their organizations.

5.1.1 Introduction to Public Health Agency of Canada

In this section, I focus on insights gained from institutional analysis of PHAC as the Crown Agency (herein Institution) tasked with promoting health activities related to HE. The PHAC is

[4] Government of Canada (2017). The Health Portfolio. Retrieved from https://www.canada.ca/en/health-canada/corporate/health-portfolio.html

mandated to report annually on the state of health of Canadians. Thus, this institution plays an important role in shaping HE debates for actions on SDH in Canada. This thesis will adopt the definition of public health advanced by the Canadian Public Health Association, which is "the organized effort of society to keep people healthy and prevent injury, illness and premature death. It is a combination of programs, services, and policies that protect and promote the health of all Canadians." (Canadian Public Health Association, n.d.)[5]. This definition has roots in Edward A. Winslow's 1920 definition that was revitalized in the Acheson Committee's 1988 report. According to Acheson, Public Health is "the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society" (1988, p.1).

Arguably, modern public health has the mandate for creating conditions for people to live and remain healthy, find opportunities to maintain their health, and prevent deterioration in their health (Schneider, 2014). The scope of modern public health has expanded beyond prevention, such as maintaining hygiene or eradication of diseases and delivering vaccines to a targeted population, to sustaining the environments that allow for the health, and wellbeing of all in society (Schneider, 2014[6]; WHO, 2021[7]). Arguably, Canada has been celebrated as one of the global leaders in the advancement of health promotion despite its struggling with the influence of neoliberalism (Hancock, 2011; O'Neill et al., 2000). In Canada, the role of public health became more focused on HE after the World Health Organization's Commission on Social Determinants

[5] Canadian Public Health Association (n.d.). What is Public Health? Retrieved from https://www.cpha.ca/what-public-health.
[6] Schneider, M-J (2014). *Introduction to Public Health*. 4th Ed. Burlington, MA: Jones and Butlett.
[7] World Health Organization/Regional Office for Europe (2021). Public Health Services. Retrieved from https://www.euro.who.int/en/health-topics/Health-systems/public-health-services

of Health released their report calling for immediate action to close the gap in a generational by adopting health equity for actions on SDH (Commission on Social Determinants of Health, 2008)[8]

5.1.2 Institutional Sites of Health Policymaking as Work from an IE Perspective

Dorothy E. Smith's understanding of institutions does not depart from the conventional sociological considerations of formal institutions as a social construct. According to D.E. Smith (1987), institutions are a stable and predictable social arrangement created deliberately to serve the needs of society. In IE, institutions are viewed as a complex of ruling relations involving multiple activities of individuals, organizations, professional associations, agencies, and the discourse they produce and circulate (D.E. Smith, 1987; Mykhalovskiy & McCoy, 2002). For Smith, the institution is best defined by what it does and how it does it; what work it produces, and how it produces that work (D.E. Smith, 1987, 2005). Focusing on PHAC as an institution guides us in identifying – from members of the organization – how their work is governed by institutional norms, practices, and traditions, some of which are visible and others are concealed (Smith 1987, 1999, 2005, 2006). The task of the IE researcher, therefore, is to make visible the invisible and ultimately liberate those individuals who are positioned within the organization who may be unaware of how their work is actually organized (D.E. Smith, 1987, 1999, 2005, 2006).

5.1.3 Institutional Analysis of PHAC

[8] Commission on Social Determinants of Health (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.int). Retrieved on Feb 28, 2022 from WHO_IER_CSDH_08.1_eng.pdf

While Health Canada has a looming presence over health and health services in Canada, its core mandate and scope differs from that of the PHAC. The two appear to have complementary and at times duplicating roles, and this is especially the case when dealing with health promotion and the SDH (Speer, 2019). There are several guidelines for inter-agency collaboration between the two institutions (Government of Canada, 2019), however, the two institutions generally remain distinctive entities in function and mandate.

PHAC's purpose is to strengthen Canada's capacity to protect and improve the health of Canadians. The agency was created in the post-SARS pandemic to build effective public health systems to enable Canadians to achieve better health and well-being in their daily lives (PHAC Act, 2006). On its website and publications, PHAC is mandated to promote good health, help to prevent and control diseases and injuries, and protect Canadians from infectious diseases and other threats to their health (Government of Canada, 2020). The government of Canada expects the agency to reduce health *disparities* between the most advantaged and disadvantaged Canadians. The agency is expected to be dynamic in coordinating its activities with all levels of government (provincial, territorial, and municipals) to *build skills* and *strengthen capacity* through collaborations. The agency also coordinates its activities with non-governmental organizations, including civil society and businesses/corporations, and international stakeholders, including other countries and the World Health Organization (Government of Canada, 2019)[9]. The terms in italics represent the positivist narratives in which the institutional roles and functions are described which we shall elaborate on later.

[9] Government of Canada: PHAC: Background. Retrieved from https://www.canada.ca/en/public-health/corporate/mandate/about-agency/background.html

5.1.3.1 A Brief Background to PHAC

As noted, PHAC was officially enacted through the Public Health Agency of Canada Act in September of 2003 in response to SARS and became a statutory Crown Agency through the enactment of the PHAC Act in 2006. (PHAC Act, 2006, herein referred to as the Act, unless otherwise specified). PHAC became the primary site for general HE policy and specific health promotion activities aimed at promoting HE and the health of Canadians. One of its mandates is to support ongoing analysis of the impact upon the availability and distribution of social and economic resources across Canada and report on it. This role is assigned to the Chief Public Health Officer under PHAC Act section 12 (1), and I quote; "The Chief Public Health Officer shall, within six months after the end of each fiscal year, submit a report to the Minister on the state of public health in Canada." (p. 4).

PHAC's role entails a disease prevention division tasked with the functions of health promotion, surveillance, and supporting scientific research on the risk and protective factors for diseases to inform evidence-based decision frameworks, strategies, and interventions (PHAC, 2015). PHAC's mandate is consistent with traditional definitions of public health as being the organized effort of society to keep people healthy and prevent injury and premature deaths (PHAC, 2020). The table below presents a summary of the role of PHAC:

Table 5. 1 The Mandate of the Public Health Agency of Health

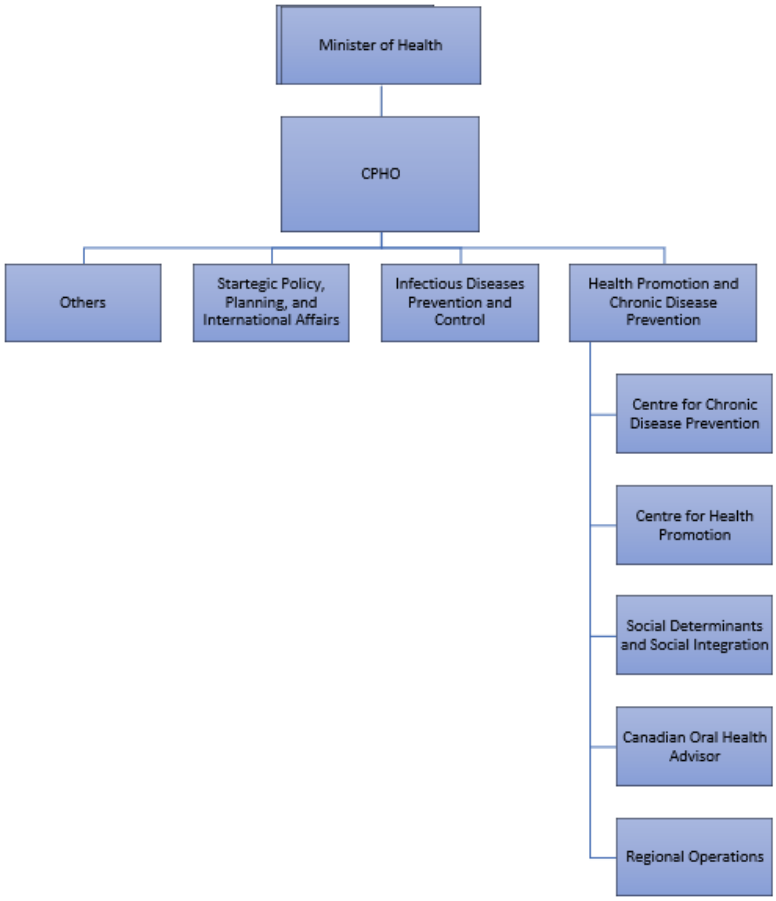
▪ Promote health. ▪ Anticipate, prepare for, respond to and recover from threats to public health; ▪ Carry out surveillance, monitor, research, investigate and report on diseases, injuries, other preventable health risks and their determinants, and the general state of public health in Canada and internationally. ▪ Use the best available evidence and tools to advise and support public health stakeholders nationally and internationally as they work to enhance the health of their communities. ▪ Provide public health information, advice, and leadership to Canadians and stakeholders; and ▪ Build and sustain a public health network with stakeholders.

Source: Government of Canada (2018). Public Health Agency of Canada Mandate. Retrieved on February 28, 2022, from https://www.canada.ca/en/public-health/corporate/mandate.html

5.1.3.2 PHAC's Bureaucratic Structure

The PHAC is headed by a President who is appointed by the Governor in Council for five – potentially renewable – years. The President is also the Chief Executive Officer of the Agency with a rank at the level of a deputy head of a department. The Governor in Council also appoints the Chief Public Health Officer (CPHO) under section 6 (1) of the Act. The CPHO is expected to be a health professional with qualifications in public health. The CPHO is the lead health professional of the government of Canada in Public Health but remains an advisor to the Minister of Health and PHAC President. The CPHO is expected to offer health advice that is "developed on a scientific basis" (The Act, 2006; The section on Advice - 1.1, p. 3). Although the Act is silent as to how the lower administrative structure of PHAC is organized, the institution's bureaucratic structure can be revealed from examining the organogram which graphically represents this structure as reproduced in the diagram below.

Figure 5. 1 Public Health Agency of Canada Organization Chart



From 2014, PHAC became corporately managed with the role of the President as CEO. The PHAC President and deputies are focused on day-to-day operational affairs (Fafard &Forest, 2016). The Chief Public Health Officer is a de facto Deputy Health Minister and works with the Associate Deputy Ministers to oversee its five divisions within PHAC: 1) infectious diseases prevention and control; 2) health promotion and chronic disease prevention; 3) health security infrastructure; 4) strategic policy, planning, international affairs; and 5) shared services partnerships. The administrative hierarchy of the organization is commanded by the vice president of PHAC, who oversees the directors general who oversee divisional directors. Each divisional director oversees departments that operate under department managers, and the managers then

oversee operations (development, implementation, quality assurances) of policy programs, knowledge production and translation, and other innovations. This section is important as it illuminates the institutional bureaucracy that complicates advancing policies with HE focus for actions on SDH.

5.2 Mapping the Institutional Hierarchy and Ruling Relations

Mapping institutional hierarchy and governing texts is an important analytical technique in IE. Turner (2006) describes mapping as a way of transcending ethnography to locate the work and texts that hook the institution processes to people's everyday experiences. In this study, I used mapping as an analytical technique to identify power locations in the hierarchies of PHAC. This analytical process revealed a social organization that is rather bureaucratic, and text governed. Mapping can make relations of ruling and the work-commanding texts visible and link them to actions that are observed. First, I mapped out the bureaucratic hierarchies of PHAC and then I identified those texts that have governing authority on these locations. In IE, identifying the social organization of work is not the goal, rather it is to explicate how it shapes the work experiences of the standpoint participants. I provide the institutional bureaucratic layout which I refer to as the bureaucratic architecture of the institution. I first present an overview of the institutional bureaucratic landscape and its implication for advancing HE/SDH concepts.

5.2.1 PHAC's Institutional Bureaucratic Landscape

Exploring the institutional architecture of PHAC revealed that it is bureaucratic and hierarchical like other government institutions. The PHAC bureaucracy is a standard top-down hierarchical structure which is inherently challenging for the promotion of HE and SDH concepts in health policy for a few reasons. First, PHAC has a corporate management headed by a President

while its health policy function is headed by the CPHO (Farfard & Forest, 2016). This institutional structural arrangement is found to be corporatized, a bottleneck to promoting health equity leads to the loss of professional autonomy (Salmon & Thompson, 2021). Farfard and Forest (2016) enumerated that the splitting of PHAC administration between the President responsible for the administration and management of Agency came with lost of power and influence, loss of voice and concerns over mobilization of resources for health policy. Second, the higher the institutional hierarchical position at which decisions are made the less likely it is that those decision makers are oriented, qualified, or understand HE/SDH concept owing to their background in business administration, social or political science.

Without health policy backgrounds, it is likely they will, rather than champion HE and SDH concerns, weaken, modify, or dilute these concepts. The study discovered that these key decision makers who lack qualifications and experience in public health, health promotion, and disease prevention frequently decide on HE/SDH-related policies and actions. Third, much of the HE/SDH considerations in health policy depend on the level of knowledge and commitments of the bureaucrats above the standpoint participants. The standpoint participants observed that once policymakers submit their reports or policy recommendations to their managers, HE/SDH concepts become subject to the scrutiny – liking or disliking - of decision makers outside of the centers and divisions where the recommendations originate. When such policy recommendations return to where it was first proposed, the health-oriented policymakers fail to recognize any trace of their evidence-based propositions. Fourth, not all bureaucrats with decision-making powers are exposed to the communities of need where policies and programs are initiated or tested for their equity effectiveness through different activities.

The deployment of bureaucrats with corporate affiliations can be interpreted as an attempt at corporate capture of the health policymaking process (Mindell, Reynolds, Cohen et al., 2012). How these corporate executives make decisions on HE/SDH, however, determines whether these concepts will filter into public policy or not. D.E. Smith (2002) acknowledges that work is organized and coordinated by organizational processes that are taken for granted and cautions that IE analysts should focus on these aspects of the institution that are impactful on people's work experiences. Below, I demonstrate how the standpoint participants enumerated their everyday work experiences in this context of the complex bureaucratic structure of the institution.

5.2.2 Key Institutional Decision-Makers Lack HE/SDH Concepts Orientation

The above findings came from the testimonies of the standpoint participants who expressed that interacting with the vertical bureaucratic institutional architecture very much limited their ability to advance HE/SDH concepts in their everyday work. The standpoint participants demonstrated that the corporate bureaucracy pervaded most of the institutional scenes where health policymaking work is coordinated and discussed. Despite these bureaucrats not being oriented to health policy, they still make major decisions on the outcome of health policy. One standpoint participant observed:

> "North America and the whole North America is structured in a way that they have a lot of vertical health promotion programs. And I think the work from the other people that I've connected you to is much more horizontal in their approach. And I think that it can sometimes feel limiting. I don't always feel like people [along the hierarchy] understand the language that I'm talking, especially when I came in talking about social determinants of

health. I was rooted in the 2010 works of Solar and Irwin and the WHO framework on SDH. None of these people paid attention to such!"

The standpoint participant demonstrated the dilemma of working in a bureaucratic institution where bureaucrats do not have backgrounds or interests relevant to a policy area. The standpoint participants further indicated that the key decision makers are not oriented to these concepts and yet they are making important decisions that are supposedly dependent on scientific evidence, which is paradoxical. The quote below demonstrates this finding:

"...not everyone in this organization is a scientist or a specialist in that area [of HE]. I think it's just important to understand the institutional part of it, especially when we have tensions. It may be that if this is an important assignment, you have to educate people on it as they come in. But ultimately, they decide whether they are experts on the specific issue or not."

From the quotation above, there may be a discrepancy within the institution because people working in a corporate structure are making decisions in health, and the CPHO, who is the health expert, is relegated to an advisory role to the President of the PHAC. This is a typical case where increasing corporatization undermines professional autonomy.

5.2.3 The Institutional Bureaucracy as Problematic

The standpoint participants elaborated what in IE is called a problematic, i.e., tensions arising from social coordination of work activities and work processes which are tied to extended social relations and text-mediated chains of action (D.E. Smith, 2005, 2006). Thus, a bureaucracy in a governmental institution becomes a problematic for policymakers when advancing HE/SDH concepts in situations where decision makers undermine these concepts. Thus, policymakers feel

conflicted when health policy decisions are made by self-interested bureaucrats who lack the expertise, knowledge, and sense of urgency for these concepts to filter through health policies. The standpoint participants reiterated that the authorities at the levels of manager, director, director general, and those at the higher ranks are the gatekeepers through which HE/SDH concepts either pass or are blocked. These individuals are in powerful positions and are able to alter, edit, re-write, or even expunge SDH/HE narratives out of policy recommendations. One of the standpoint participants demonstrated this experience this way:

> "If I make policy recommendations about a specific issue and use the language such as SDH or HE and my manager does not see it that way, it may never move to the next level or gets edited out. I suspect it is the same for those above her such that by the time the report reaches to the top, it is so watered down that the initial meaning is lost in translation."

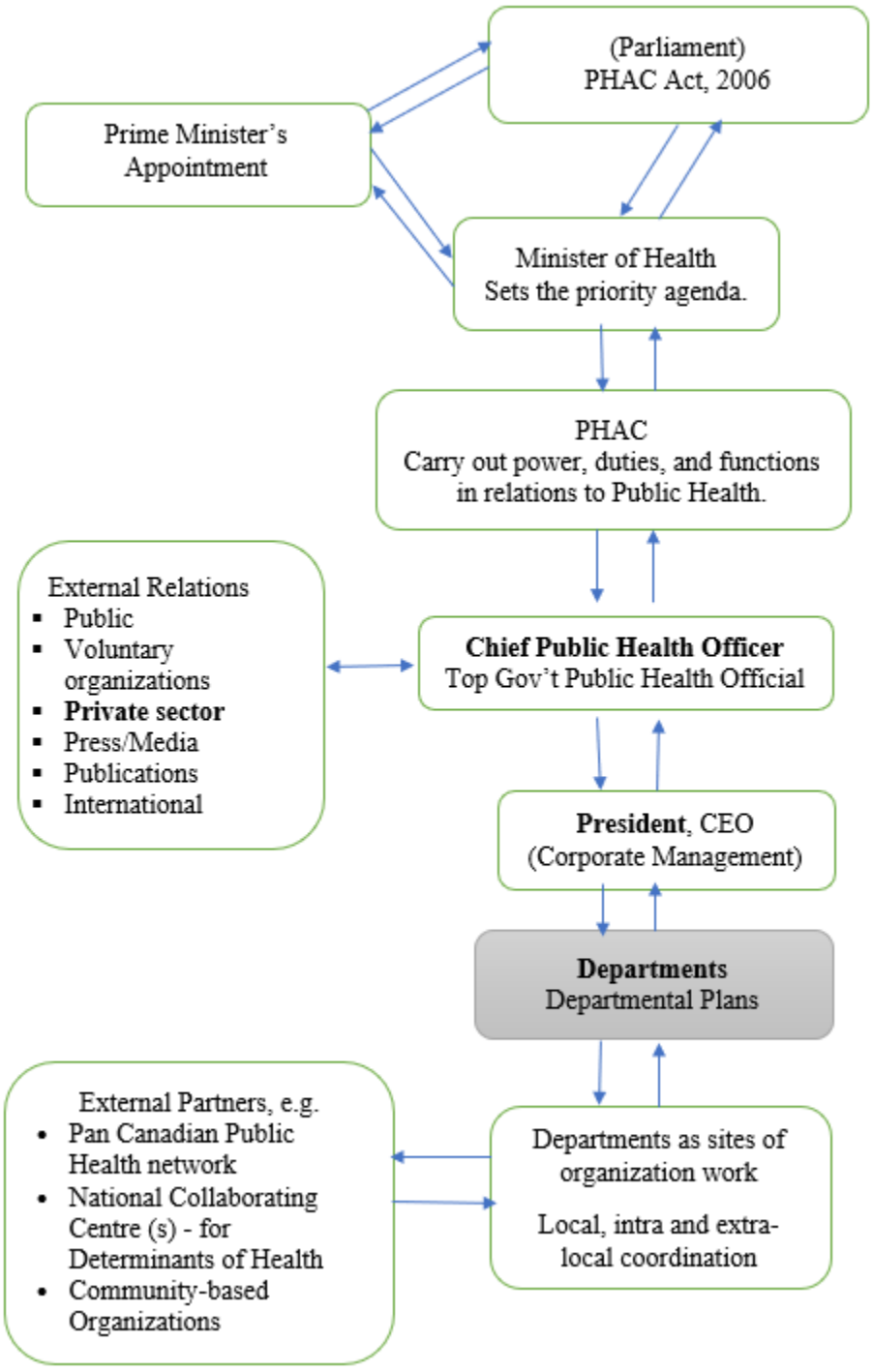
The above citation embodies the challenges of moving HE in policy for action on SDH within the institutional hierarchy. The organizational structure and its bureaucracy determine whether HE/SDH concepts remain visible or are removed from the health policy agenda.. Depending on the health orientations of these bureaucrats HE/SDH concept may be filtered out of policy texts as these ascend or descend the rungs of the bureaucratic institutional structure. These contextual complexities reveal the ideological characters of this institution and the conceptual practices of power in an institution more suited to manage health issues rather than promote HE through SDH-related HE public policy action. In the next section, I present the institutional texts, textually mediated processes, and textual analysis that make for either for visibility or invisibility of HE/SDH concepts. In the next section, I examine texts and text-related relations of ruling as a

means to problematize institutional bureaucracy as a challenge for promoting policies with HE considerations.

5.3 Textually-Mediated Processes in HE-Related Policymaking at PHAC

The role of texts in coordinating institutional activities has been enumerated in the methods section. This section presents textually-mediated processes and how they organize policymaking in PHAC. In IE there are various types of recognizable texts that govern institutions. D.E. Smith, however, differentiates between the boss texts and higher-order texts (Bisaillon, 2012; Stanley, 2018) According to Bisaillon (2012), the boss or governing texts refer to "a text or set of texts that supplies the context of what we can see, hear, and know." (p. 610). The boss texts are authorized through institutional procedures through which specific people are instructed to conduct specific practices. The boss text coordinates organizational relations "so how people work is controlled in conformity with the selective requirements of the boss text" (p.610). Bisaillon (2012) acknowledges that there are subsidiary documents that fall under, are produced by activation of aspects of the boss texts and are organized by them. These subsidiary texts are higher-order texts and subordinate texts also described as lower-order texts (Stanley, 2018).

Figure 5. 2 My summary of the process interchange map and the feedback mechanisms of policy work processes in Canada.



The above diagram is a map of the process interchange illuminating the complex hierarchical pathway through which health equity-related policy recommendations flow. The

information was gathered from analyzing multiple texts and the social organizations that result from activation of these texts, thus demonstrating a process interchange (Pence, 1996 as cited in McVault & McCoy, 2005).

5.3.1 Processes Interchanges – The Reporting Hierarchy

In IE, process interchanges are institutional practices or organizational occasions of action in which one practitioner receives a document from another, such as an annual report, a memo, policy briefs, or draft policy documents, and makes something out of it; acts on it; or forwards it on to the next organizational occasion for action (Pence, 1996 as cited in McVault & McCoy, 2005). These organizational occasions of action are important to pay attention to because they may reveal aspects and/or objectives of important HE-related activities.

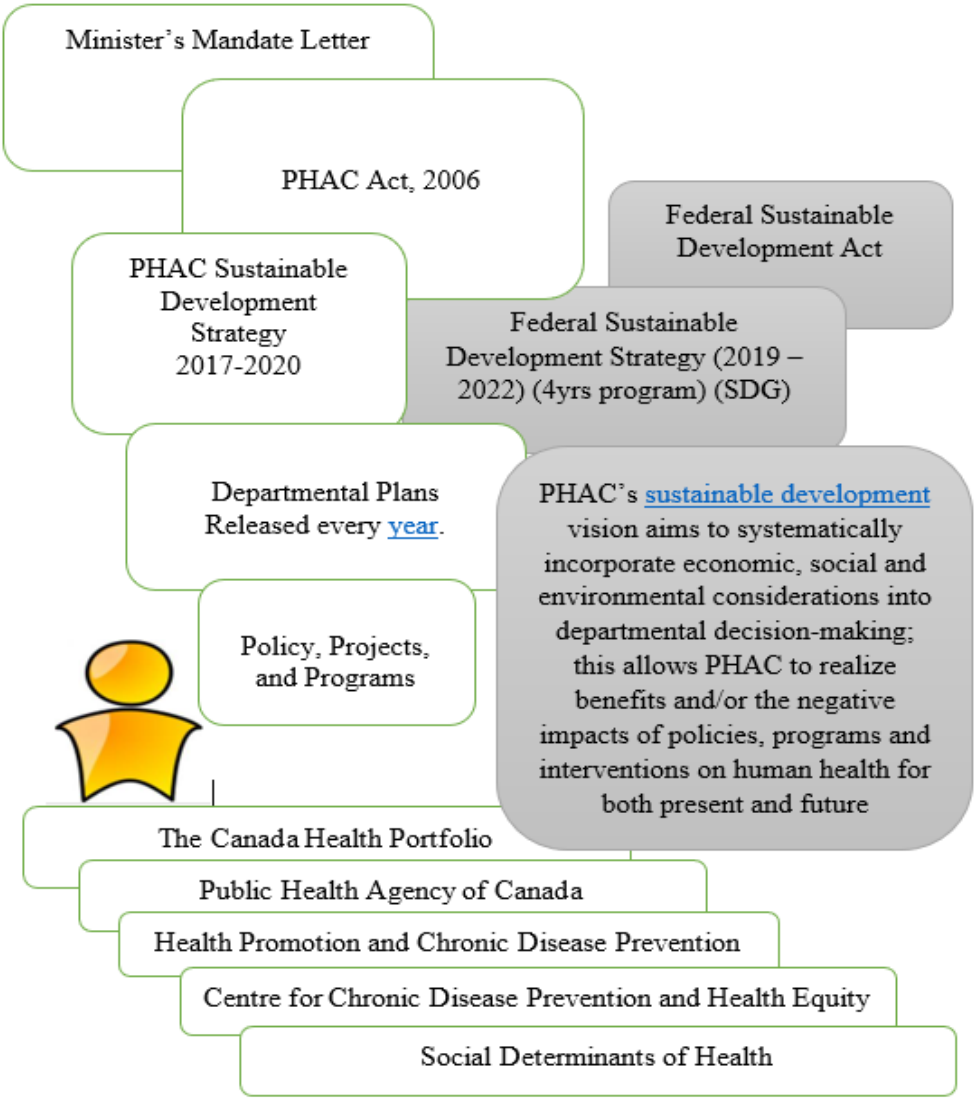
In this regard, the standpoint participants demonstrated that policy reports that contain HE recommendations may become activated, suspended, or suppressed along with the bureaucratic gridlock. Understanding the process interchange as part of institutional bureaucracy may make policymakers' concerns visible. During this process, when policymakers submit policy recommendations with required evidence supportive of HE/SDH concepts, these recommendations get altered, diluted, ripped from its social justice context, or even replaced altogether from the final health policy recommendation. By the hierarchical nature of policy work, policy recommendations begin their journeys from one point and climb through bureaucratic ladders as the recommendations get filtered from various institutional influencers. In the next section, I present a mapping of institutional texts and the location of the standpoint participants.

5.3.2 Identifying Texts and Inter-Textual Relationships at PHAC

In the next section, I present discoveries from influential institutional texts. These texts define the ruling relations and social organization of health policymaking as work. The texts also define institutional character i.e., values, traditions, practices, and expectations (D.E. Smith, 2005, 2006). Additionally, the texts transmit the ideology of dominant groups in power, thereby determining the conceptual practices of the institution and activities at the multiple policymaking sites. The boss text is the Health Minister's Mandate released on Dec 13, 2019, and a supplementary letter dated January 15, 2021. My aim in analyzing these texts was to locate how HE/SDH concepts were conveyed. Further, I present how the text's language and its directives make HE and SDH concepts explicit or implicit, and how these directives become interpreted and activated by those it socially organizes. I then present discoveries of these concepts as are made visible or invisible in subsequent high order texts, the Public Health Act, 2006, and subordinate texts – the Departmental Plan of PHAC. These texts reveal how the organization of policymaking work at the department and how HE/SDH concepts are promoted, resisted, or subordinated.

In figure 2 below, I present the general overview of the ranking of authoritative texts that govern the ruling relations at PHAC. These texts are not time bound documents, rather, they represent texts every government of the day uses to organize health policymaking in the context of this study. The Minister's mandate letter is considered the boss or high order text (Bisaillon, 2012). When activated, it produces or activates aspects of the texts below it in that sequence. The texts are assessed for how the ideology and agenda of the government in power is transmitted from the top to actual sites of policymaking - what kind of structures and functions they create and how these texts socially organize policymaking as work on HE/SDH. The text in darker colors demonstrate how the Agency's works are connected to and with other agencies extra-locally.

Figure 5. 3 A summary of Institutional Texts and Inter-Textual Mapping



The above figure illustrates my summary of the text relations to the policymaker's standpoint and texts that relate to transmitting relations of ruling in PHAC. How the texts are linked and communicate with each other from the point of origin to the point of activation determines relations of ruling and social organizations' policymaking as work along the hierarchy.

5.3.2.1 The Health Minister's Mandate Letter

The Minister's mandate letter is the instrument of authority that the Prime Minister provides to his/her Ministers. The letter details and conveys the health policy priorities of the ruling party which highlights its ideological standpoint on achieving health equity tailored policies for actions on SDH. This section describes and provides a summary of the Health Minister's mandate letter and the Health Minister's supplementary mandate letter issued amid the pandemic.

Once constituted as Prime Minister (PM), the PM appoints Ministers, Deputy Ministers, and Secretaries to form the government of the day. The PM communicates these appointments through a Ministerial mandate letter. This letter details the scope of the Minister's mandate and priority actions for each ministerial appointee. The Health Minister's mandate letter mediates relations that ground policymakers in health-focused institutional sites, and thus this mandate letter becomes a subject for analytical practice in IE as a governing or boss text (Bisaillon, 2012; Stanley, 2018). The goal for an IE researcher is to turn their gaze from the appointee to the textually-mediated relations in which the appointee's knowledge, intentions for action, and experiences become situated. The researcher explicates the relations that shape these experiences (DE Smith 2003, 2006; Prodinger & Turner, 2013).

The current Liberal government was first elected in 2019 and their first Health Minister's Mandate Letter (HMML) was released on December 13, 2019. A supplementary HMML was issued on January 15, 2021, to address pandemic-related emerging health priorities. The HMML, therefore, sets the tone for Canada's health agenda. Overall, the above texts offered a broad array of progressive policy agendas for health equity and actions on SDH. These progressive policies, however, do not imply that the government acts on all that it promises. Below are the highlights of the policies that I found to be progressive within the HMML.

In particular, the Liberal government's central organizing principles or health policy agenda as conveyed in the HMML focused on investing in families and communities, creating good middle-class jobs, fighting climate change, and keeping the economy strong and growing. Additionally, the HMML also directed that the Health Minister takes actions to make the life of Canadians more affordable, strengthen the health care system, protect the environment, keep communities safe, and achieve reconciliation with the Indigenous peoples of Canada.

Specific to the health portfolio, the Prime Minister outlined several priorities that were wide-ranging in scope. Top on the agenda is the directive to the minister to lead intergovernmental efforts to strengthen Medicare, renew health agreements with the provinces and territories to ensure easy access to a family doctor or primary health care, make access to national mental health services possible, improve access to home care and palliative care, and implement national universal Pharmacare including establishing the Canada Drug Authority. Other pertinent priorities include plans to amend the Canada Health Act and ensure that provinces comply with its provisions.

To achieve these broad goals, the Health Minister was mandated to work with other orders of government to address drug use and substance use crises; work with communities to expand community-based services, expand rehabilitation, support autism and other ailments, and prioritize harm reduction measures.

The PM directed the Health Minister to collaborate with other ministries and support the production of knowledge for evidence-based decision-making. The Minister is expected to roll out programs that strengthen communities, address youth vaping problems, institute accessible mental health services, and focus on reducing gender-based inequities (Office of the Prime Minister,

2019)[10]. The HMML further commits the Minister to a high standard of transparency, accountability, requiring that the person upholds the highest possible ethical standards and applies the utmost care and prudence in handling public resources.

The Minister of Health supplementary mandate letter issued on January 15, 2021, addressed specific actions that the Minister should execute in the management of the COVID-19 pandemic. These recommended actions were geared towards enhancing health equity in access to services for the most disadvantaged population as the pandemic was revealing (PHAC, 2020)[11]. The renewed mandate of the Minister in the Minister of Health supplementary mandate letter directed inter-governmental collaborations to be strengthened in order to maintain previously ongoing commissioned policy works. It further recognizes the wide-ranging socio-economic inequities that COVID-19 had exposed, thereby requiring the minister to take actions to enhance public safety while keeping costs of basic health services, including drugs low. It further mandates the Minister to augment international collaborations to ensure that people around the world have access to resources to fight COVID-19, including vaccines, therapeutics, and strengthening health systems (Office of the Prime Minister, 2021)[12].

One of the striking features of the supplementary HMML is its emphasis on inter-governmental collaborations as it relates to silos in government. The emphasis on inter-governmental collaborations should have targeted reducing departmentalization or silos in government where one government department, say of housing or labour relations, do not communicate with the department of health at all levels of policymaking. Labour, Housing and

[10] Office of the Prime Minister (2019). Minister of Health Mandate Letter. [Archived] Retrieved from https://pm.gc.ca/en/mandate-letters/2019/12/13/archived-minister-health-mandate-letter
[11] Public Health Agency of Canada (2021). Social inequalities in COVID-19 mortality by area- and individual-level characteristics in Canada, January to July/August 2020. Ottawa, ON: PHAC; 2021.
[12] Office of the Prime Minister (2021). Minister of Health Supplementary Mandate Letter [Now Archived]. Retrieved from ARCHIVED - Minister of Health Supplementary Mandate Letter (pm.gc.ca) (https://pm.gc.ca/en/mandate-letters/2021/01/15/archived-minister-health-supplementary-mandate-letter)

Health departments should be working together to address minimum wage and income guarantees, and improvement to working and living conditions. Intergovernmental collaborations are, however, not evident as we shall see from the standpoint of policymakers. Government departments hold resources, yet a persistent lack of coordinated effort undermines collaborative work on promoting HE/SDE concepts in all the government policies. In the next section, I report on discoveries of how the concepts of HE/SDH are made visible or concealed in the Health Minister's mandate letter, followed with a similar presentation of the Health Minister's supplementary mandate letter.

Table 5. 2 A list of some selected Interactive Institutional Governing Texts that govern health policymaking as work at PHAC and were analyzed for the social organization of work promoting health equity tailored policy for action on SDH.

Text Producing Authority	**Documents that define relations of ruling**	**Authority of the Document**	**Some Expected Outcomes**
Prime Minister and Cabinet	The Health Minister's Letter of Mandate Minister of Health Supplementary Mandate letter	• Political statement of the government of the day on health policy direction • Authority for the Minister of Health to act in support of government's agenda • Issued each time a reshuffle of the health minister occurs	• Community engagement and collaborations • Evidence-based decision-making • Use of Gender-based Analysis Plus (GBA+) in decision-making. • Strengthen Public Health care – improved focus on mental health and access to specialists. • Steps towards universal Pharmacare and dental care
	PHAC ACT 2006	• Establishes PHAC • Defines roles and responsibilities of Minister, CPHO and President	• Protecting the Health of Canadians • Collaborating with Canada's health portfolio,

		• Stipulates expectations of the Organization	private sector and global coordination of health securities
Minister of Health	PHAC Departmental Plan	• Annual statement of the Minister's mandate • Organizes how the Minister's mandate is carried out	• Guide priority action plan for the year • Implementation of the agenda in the Minister's mandate letter
Department Specific interactive texts	Departmental Sustainable Development Plan	• A 3-year iteration plan for the absorption of health policy activities budget • Required for Treasury Board solicitation.	• Money released to facilitate policy activities of PHAC • The smooth operation of PHAC • Monitoring equity impact and improvement of health

5.3.2.2 HE and SDH in the Minister's Mandate letters

In analyzing the HMML for HE/SDH concepts, I discovered no explicit mention of these concepts as a priority in health policy, although they were implied in some directives. For instance, one would interpret the directives to make universal Pharmacare and certain health care services accessible, including access to physicians for Canadians to imply removing or decreasing inequities. Furthermore, services that were targeted as action priorities included community safety, youth vaping, addressing autism and rare diseases, addressing sex and gender-based disparities using gender-based analyses such as the gender-based analysis plus framework. These priorities

tend to confirm the individual and behavioural/choice intervention types that do not address equity at a societal level. Nonetheless, these policies still speak to actions on equity policies. The PM was explicit in directing those actions to be taken towards mitigating environmental and climate change impacts on health. The mandate letter also prioritized the promotion of healthy eating as opposed to a collaborative approach to addressing rising food insecurity. Incidentally, there was an explicit mention of poverty eradication as a role that public health should play at a national level.

It is conceivable that the HMML is implicit in actions on SDH which are left to the interpretation of the Minister and the Ministry of departmental officials. For instance, access to health care and community safety by fostering social inclusion are moments when SDH are recognized (Raphael, 2016). Baum and colleagues argue that strengthening the health care sector and making it accessible is itself a vital determinant of health (Baum, Begin, Tanja, et al., 2009). There has already been so much innovation in health care, however, the creation of much-needed universal Pharmacare has not materialized (Hutchison, Abelson, Lavis, et al., 2001). According to Bryant (2016), sufficient evidence reveals that the health care system has resisted change or missed the opportunity to address HE for a while. Arguably, the HMML was written in such a way that departmental actors have opportunities to interpret and act on health inequities and develop policies to address them. The lack of clarity on what measures or actions to take to achieve these policy objectives has often led to novel interpretations of what constitutes HE or concrete actions on SDH. This is consistent with the understanding of the standpoint participants as demonstrated below:

Interviewer: “How explicit is this Minister’s mandate letter on HE and SDH concepts to you?”

Standpoint participant: "The Minister of Health's mandate letter does not explicitly mention the social determinants of health. But, certainly in reading through it and our interpretation of what that means for our work it is clear. I mean, using language such as 'commitment to promoting diversity/multiculturalism' or you know 'addressing family violence'. So, I think a lot of, without explicitly saying, social determinants of health, a lot of the actual mandate, or commitment or work that is passed to the Minister and our department, does directly address or aim to address key determinants of health."

In reflecting how the lack of explicit mention of HE/SDH plays out at this political level, I ventured into reading the mandate letters of other Ministers. I discovered that HE and SDH issues are dispersed across other government line ministries. It then became reasonable to state that a fair evaluation of the government's efforts at addressing HE/SDH concepts requires pursuing a government-wide analysis of policy priorities, programs, and interventions. Such an undertaking, however, becomes cumbersome due to governmental silos but also unveils a phenomenal level of ambiguities as we shall discuss later. For instance, while the HMML does not mention the role of the Minister in leveraging an increased minimum wage, an important SDH, it is explicit in the Labour Minister's mandate letter in which the Minister for Labour is instructed to ensure that the minimum wage is elevated to $15 per hour.

The supplemental HMML released on January 15, 2020, mentioned HE but did so broadly about upholding the principles of gender equality, disability equality, pay equity, and social inclusion. Central to its conceptualization of equity are the government's commitments to evidence-based decision-making that takes into consideration the impacts of policies on all Canadians and defends the Canadian Charter of Rights and Freedoms. The PM further directed the

Health Minister to apply Gender-based Analysis Plus (GBA+) in the decisions she makes and consider public policies through an intersectional lens to address systemic inequities such as systemic racism; unconscious bias; gender-based discrimination; barriers for persons with disabilities; discrimination against LGBTQ2 communities; and inequities faced by all vulnerable populations.

The Minister is further guided that whenever possible; she works to improve the quality and availability of disaggregated data to ensure that policy decisions benefit all communities. The PM further directs the Minister to pursue inter-departmental collaborations, community consultations, and a broad approach to engaging the public and private sector for innovative solutions to the health challenges faced by Canadians (Office of the PM, 2019). It appears that the supplementary HMML was more equity-focused in describing actions to address health inequities. Arguably, this equity focus in the supplementary mandate letter was triggered by COVID-19 which made social and health inequities become visible and its dramatic effect felt with shame (Jenkins et al., 2021; Tuyisenge & Goldenberg, 2021). The key focus of the pandemic containment directive included enhancing the quality of life in long-term care for seniors, supporting increased access to COVID-19 containment measures across the provinces and territories; making vaccines available; accelerating national Pharmacare while ensuring that the opioid crisis is contained; and implementing targeted measures for personal support workers who provide critical essential services to the most vulnerable (Office of the PM, 2020).

While the HMML may not have been very explicit in its call to equity actions, its directives could mainly be achieved by incorporating health equity thinking. Additionally, some of the recommended actions, when properly interpreted and implemented, could result in a significant reduction in health inequity outcomes. On the other hand, the HMML lacked a unified institutional

conceptualization of HE/SDH concepts; did not demonstrate the need to redress historical and socially entrenched causes of inequities, and above all, its singular proclivity for scientific evidence excluded experiential knowledge. The latter could further alienate the Indigenous peoples and people of color whose experiential knowledge of inequities and injustices may fall behind scientific evidence. Furthermore, the government's reality is that where opportunities for joint action on HE/SDH concepts may exist, such issues are dispersed and siloed in different departments and ministries. This incongruence renders any meaningful intentions dull and may lead to delays to act, and at times, it may lead to duplication of services at high costs to taxpayers (Peer, 2019).

5.3.3 The Public Health Agency of Canada Act, 2006 (PHAC)

In this section, I turn to the Public Health Act, 2006, a subordinate text to the HMML. This text establishes PHAC as a Crown Agency and stipulates the institution's mandate, as well as the roles and responsibilities of its leadership. I found that this text was relevant because it defines roles and places expectations on officer bearers in a way that they become the gatekeeper for HE/SDH concepts in health policy. The PHAC, 2016 (or The Act, 2006 for this section) distinguishes the role of the President as the Chief Executive Officer and describes the corporate functions of that office bearer, which was not my focus of study. The Act also describes the roles and responsibilities of the Chief Public Health Officer, as the Chief Government Health Advisor and Advisor to the CEO. What roles do they play in promoting health equity? What are their mandates and responsibilities?

The Act – 2006 section 12 (1), mandates the CPHO to submit an annual report on the health of all Canadians titled *The State of Public Health in Canada* to the Health Minister within six

months of the end of each fiscal year. Section 12 (2) requires that the Health Minister causes the report to be laid before each House of Parliament on any of the first 15 days on which these houses sit.

The snippet above describing a sequence of actions between the CPHO and the Minister are important IE moments because they map out work-related institutional processes and process interchange in identified institutional sites. These processes happen as a result of many health policy activities within an institution to accumulate and shape health policies through sequences of text activation and coordinated events. Such an analysis enables the reader to identify what the CPHO as a public health officer must do, and which must be done in the fulfillment of her role in the chain of policymaking activities. Ranking (2017) guides IE users to value mapping and indexing because these allow organizing data into linked practices. Mapping also reveals ruling relations most of which are mediated textually and likely lead to the production of additional texts related to policy development and implementation. Consequently, each additional text produced as a consequence of activating a higher-order text is a subject of IE researcher's analytical interest.

As I proceed with presenting and discussing discoveries, emphasis on unpacking the process interchange is important for studying processes and linkages between activities within an institutional policymaking work. Policy work, therefore, is not the sole product of an individual or even a group's efforts. Rather, it is a combination of activities, documentation, contests, and contestation, discourses, discourse analyses, and so forth, which in many cases will involve some tactics that may be revealing, concealing, subverting, and sometimes maneuver to suppress minority views and override evidence before obtaining the final policy consensus.

5.3.3 Mapping HE and SDH in PHAC Act, 2006

HE is not explicitly mentioned in the PHAC Act, 2006 as one would expect. Arguably, pursuing HE should be part of the legislated role of the CPHO. The roles and qualities of the CPHO are laid down in section 6 (2) of the Act. The CPHO is expected to be a versatile public health professional and section 7 (1) designates the CPHO as the lead professional of the government of Canada concerning public health while section 7 (1) (1), states CPHO is the lead adviser to the Minister of Health and the President of PHAC, makes the CPHO a potential advocate for HE/SDH concepts. As an Advisor, the CPHO is expected to rely on evidence developed on a scientific basis (Government of Canada, 2021). This provision may be restrictive to exclude experiential evidence, it also reinforces the rigid biomedical standards.

The Act does not define Public Health; however, it assigns the CPHO as someone who could promote or undermine HE and SDH concepts, being a signatory to the annual report on HE/SDH. As the signatory to the Annual State of Health of Canadians' Reports, the CPHO could ensure that HE and SDH concepts are made visible in public health discourses in Canada, in her report, and in the various policymaking worksites, in order to reduce health inequities across Canada.

A summary of the CPHO's annual reports draws attention to the potential of the CPHO for advancing HE/SDH. For instance, in section 2 of the 2020 report titled *From Risk to Resilience: An Equity Approach to COVID 19,* the CPHO identified that COVID-19 is not impacting Canadians equally. The report indicated that health inequities reveals that the same groups in the Canadian society who were most vulnerable to COVD-19 are the same that were also disproportionately being impacted by public health measures to prevent COVID-19. The report further recognizes that the structural determinants of health such as social and economic policies, governance structure, societal values, and norms were driving health inequities. Issues such as the

history of racism, colonialism, and discrimination that was exacerbating inequities during the pandemic became prominent. The CPHO's annual 2020 report explicated the intersectionality of the impact of COVID-19 with sex, gender, racialization, income, housing, employment, and various socio-economic factors. In section 3, the report recognized that income, employment, and working conditions were the most critical action areas, citing the Bank of Canada's concern for a potential "steepest and deepest economic decline since the great depression" (Macklem et al, 2020[13] as cited in CPHO 2020 Report). Overall, I examined and found that the CPHO's 2020 annual report was measured, progressive, and made HE/SDH concerns quite visible. This report attests to the potential of CPHO to commit the government to promote health policies that are practical in its commitment to actions on SDH through health equity-focused policies.

Additionally, when I compared the CPHO's 2020 annual report with the 2019 report titled *Addressing Stigma: Towards a More Inclusive Health System*, the latter focused entirely on the impact of stigma on the health of Canadians. The 2019 report recommended a multi-level approach to fight stigma using the Stigma Model to address individual, interpersonal, institutional, and population-level factors associated with stigma resulting from poverty, mental health, etc. The root cause of poverty in Canadians is not stigma, rather the unequal distribution of social and economic resources, which also reveals the pattern of distribution of power and privileges (Raphael, 2015; Bryant, 2016; Carrol & Sapinski 2018). Moreover, the incidences and negative impacts of poverty in Canada have been repeatedly attributed to the declining redistributive effect of the Canadian welfare state, thus the reason Canada has one of the highest numbers of poor individuals and families in developed countries (Banting and Myles, 2018; Raphael, 2020[14])

[13] Macklem, T. et al. Monetary Policy Report. Bank of Canada (2020).
[14] Raphael, D. (2020). Poverty in Canada: Implications for Health and Quality of Life. 3rd Ed. Toronto: Canadian Scholar.

I looked further to the CPHO's 2017 report and it focused on *Designing Healthy Living*, and reducing chronic diseases, prevention of injuries, promoting physical activities, healthy diets, and mental wellness. The report never discusses how these actions address income inequality and other facets of the market economy that has disengaged Canadians from the optimistic view of their country as humane (Raphael, 2020). Thus, in analyzing the past CPHO annual reports, one can see trends where it is strong on midstream and downstream recommendations that target individual behaviours or built environment. Some of the recommendations are explicit on the role of the private sector in health policy innovations. These policy recommendations are traditional and rooted in narrow approaches to health equity solutions (Bryant, 2016). Conclusively, I found that the CPHO's 2021 report was rather more proactive in calling for the addressing of glaring societal inequities that were exposed by the pandemic (Government of Canada, 2020).

The implication of analyzing these reports is to reiterate that having a CPHO who is progressive and works in a supportive environment, could bring the government to account for its promises to promote health equity. Achieving HE in health policy requires addressing the social and material deprivation across society that may be explained from neo-materialist perspectives. The neo-materialist framework is concerned with the objective living conditions as an explanatory approach for how SDH shapes health outcomes (Raphael, 2016). Thus, an example of a recommended solution to reducing health inequities is enacting policies that reduce the material disadvantages among the population by redistributing social determinants of health, such as guaranteed minimum income, minimum wage policy, promotion of unionization, stable employment and education, affordable housing, recreation, and universal childcare. Understandably not everyone agrees with the neo-materialist stance or are of it, while others are blatantly market-oriented, such that health equity is an anathema to their profit margins.

To place the CPHO reports in context, I analyzed publicly available information about the current CPHO (Government of Canada, 2021). For instance, on her PHAC webpage, the current CHPO's vision statement recognizes the critical role that the SDH concept plays in shaping positive health experiences for Canadians. However, after studying her practice priorities, that vision statement is not reflected anywhere. the textual analysis of the CPHO's medical practice priorities illuminate a practice that favour individualistic and biomedical approaches. It is worth concluding that a great opportunity in the role of the CPHO for advancing HE/SDH concepts in health is not being fully optimized. This has been the case because all of the Chief Medical Health Offices of Canada's reports certainly did not address structural issues of resource distribution, power and influence.

This is partly due to preferences for the biomedical and individualistic approaches at explaining health inequities, all of which are reinforced by the institutional conceptual practices of power. McGibbons, Fierlbeck and Ajadi (2021) acknowledges that positivism has dominated health policy research and design for a while such that empiricism overshadows values, life experiences, biases and interests. This may partially explain why it took the coronavirus pandemic for the institution to admit the glaring increase in social inequities in Canada. This should not have been the case if the CPHO's commitment to HE/SDH concepts focused on addressing structural issues of resource distribution, power and influence. In the next section, I turn to the analysis of the next lower text: the Annual Departmental Plan

5.4. The Annual Departmental Plan

The next text that is instrumental in socially organizing policymaking as work across PHAC is the Annual Departmental Plan. Although the Departmental Plan is issued every year, it

has a three-year iteration time frame. It is an annual document issued by the Minister of Health to guide the priorities of PHAC. It is linked to departmental funding and details expected outcomes. A brief content description of current and previous departmental plans may offer insight to the readers.

The 2021-22 Departmental Plan (Plan) focuses on containing the COVID-19 pandemic and promoting economic recovery. The Plan is focused on ensuring that Canadians have access to vaccines to protect them against COVID-19. It promises strong immunization surveillance systems to monitor the safety and efficacy of the vaccines. Outside of promoting vaccine uptake, the Minister also directs PHAC to conduct public education to address evolving issues relating to vaccine hesitancy and to provide useful, timely, evidence-based information to Canadians. The document further highlights the institutional action plan for mental health challenges, substance use and substance-related harms, and suicide prevention. The document also guides PHAC to develop a national autism strategy and to provide funds to support Canadians that face health inequities and are at a greater risk of chronic diseases (PHAC, 2021[15]).

Within the plan are community-focused funding programs. The Healthy Canadians and Communities Fund, for instance, is to support grassroots communities across Canada to improve their health behaviors and create environments to enable healthier choices. Under the current Departmental Plan (2021/22), the Health Promotion and Chronic Disease Prevention division is tasked with conducting surveillance and public health research and supporting community-based projects to address the root causes of health inequities, common risks, and protective factors. The three departmental results/outcomes expected are: a) Canadians to have improved physical and

[15] Public Health Agency of Canada (2021). 2021-2022 Departmental Plan: Public Health Agency of Canada> retrieved on February 23, 2021, from https://www.canada.ca/en/public-health/corporate/transparency/corporate-management-reporting/reports-plans-priorities/2021-2022-departmental-plan.html#a31

mental health; b) Canadians to have improved health behaviors; and c) prevent chronic diseases. The Plan is linked to the Departmental Sustainable Strategy which contributes to the Federal Sustainable Development Strategy (FSDS). The FSDS is a three-year plan that is required by the Federal Sustainable Act to map health policies, projects, and programs to Canada's commitment to the Sustainable Development Goals (SDGs). The standpoint participants are hooked onto this complex textually-coordinated institutional operations from local to extra-local, and happenings through policy, project, or program activities that are expected to run for three renewable years.

Examples of other 3-years plans include those for addressing the mental health challenges faced by Black Canadians, Pan-Canadian Suicide Prevention services, Aboriginal Head Start in Urban and Northern Communities (AHSUNC), Indigenous Early Learning and Child Care Transformation Initiative (IELCC), Prevention of Gender-Based Violence: the Health Perspective, and so forth.

In sum, the Departmental Plan (See table in appendix for summary) is a ministerial guided action plan that lays down the government's priorities in promoting health in Canada. Although it is an annual plan, it reinforces and guides existing iterations that usually run for at least three years. Much of the guidelines are textually coordinated and hook the policymakers to local, translocal, and extra-local health policymaking sites. This interconnectedness ensures that Canada can meet its local and international commitments to HE. Nonetheless, the constellation of these activities has not guaranteed that Canada is pursuing HE as the cornerstone of its public policy to reduce inequities in the redistribution of the socio-economic resources to all Canadians. Much of the programs are directed to knowledge production, individual behaviour change, and where communities are involved, programs hardly consult and integrate the community's experiential knowledge. Thus, the conclusion of my discoveries after analyzing the Department Plans is that

the commitment in policy language is not matched to the actions required to achieve HE. Below, I discuss some of my discoveries that support my deductions.

5.4.1 The Departmental Plan and Social Organizing of the Worksites

The departments are the functioning units in PHAC where real policy activities such as testing the effectiveness of policies, programs, and innovations occur. The department interfaces with the community for engaging them, getting feedback, and evaluating policies. Worksites as socially organized locations refer to the social organization of knowledge and people's concerted activities in those worksites (D.E. Smith, 2006). The "social" here is defined as people's ongoing actions as these happen in coordination with the activities of others in "across-time-and-place conversations" (D.E. Smith, 1996, p.46 as cited in Bisaillon, 2012, p.618). Bisaillon (2012) has argued that social organization and relations produce the social and learning that forms the basis of the institution. Thus, D.E. Smith borrows the concept of social relations from Karl Marx's analytical work to signify how the coordination of people's activities across multiple sites involves groups of people who may not even know each other nor meet face-to-face (DeVault and McCoy, 2006).

The way policymaking as work is socially and institutionally presented can be appreciated by research. In the preceding section, I attempt to map out the structures and local sites where activities we deemed as policymaking occur. In PHAC, most of the activities that contribute to policymaking as work take place in the various branches, centers, and divisions, such as the Social Determinants of Health division. It is here that epidemiologists and various health promotion specialists with work history, knowledge, and qualifications in concepts of HE and SDH interact vertically and horizontally with the communities of need.

Some activities, however, require coordination beyond the local to the translocal and extra-local. The Annual Departmental Plan socially organizes policymaking work in the institutional sites through several principles; among which these three are primary: a) funding external organizations to implement policy, programs, and innovations that socially produce knowledge used to inform policies and other programs; b) using innovative approaches to gain better results from policies, programs and innovations; and c) universality to ensure that all Canadians participate in policy implementations, programs, and innovations. In the next section, I explicate the work experiences and what policymakers do under each of the guiding principles.

5.4.2.1 Funding External Organizations

One of the core functions of the divisions is holding and distributing funds to grassroots organizations to implement policies, programs, and innovations. This is a core function with activities that transcend time and sites. The funding is also expected to generate knowledge or evidence to inform policies. One standpoint participant identified that providing funding to grassroots organizations comes with an expectation to spur innovative interventions (policy, programs, and innovations). One standpoint participant described this work as follows:

> "I work specifically for a large funding body on the side of policy implementation. I don't know if there was a policy that came forth to have this funding, but it's a population health intervention fund. And it has gone through several changes in the last couple of decades. It's a very long-running fund. And what they do, they crafted, I don't know, we're talking maybe in the 90s it was originally developed with the idea to fund organizations to not just do behavior change work but also to effect change in the upstream determinants of health."

The above quotation demonstrates that the institution may have inherited the fund referred to in the above quote from a previous program intended to promote HE before the formation of PHAC. Importantly, the standpoint participant believed that the funding was intended to address social inequalities across Canada. There is a whole slew of population health literature that was critical of Canada's acceptance of the population health approach in the 80s and 90s and perhaps this fund could have originated there.

Another standpoint participant describes the social organization of their work and highlighted the links between the funding mandate and collaborative work with grassroots organizations towards equity-related policy change:

> "So, we have some experience in mental health promotion, but we also have experience in wider health promotion including food security. The way that we work is we fund that term think globally and act locally. That's what we do. So, we fund different organizations across Canada, so that they can implement interventions, but also with an eye to underlying determinants of health which means often policy change, right, so that often means multisectoral policy change the ideas of health in all policies."

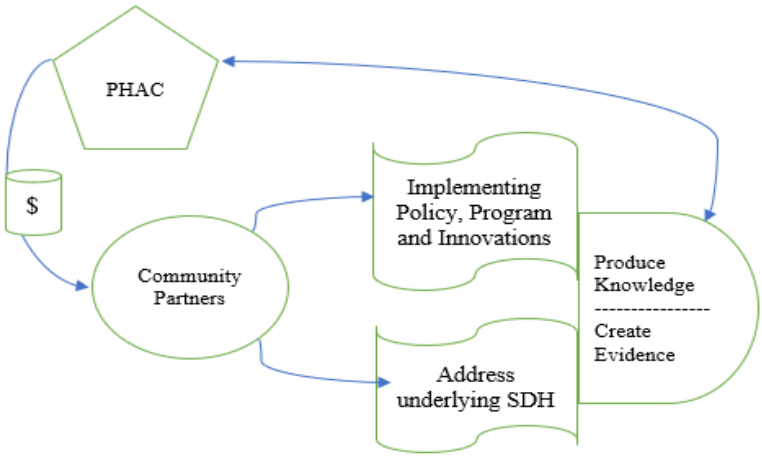
The insight in the above quotation is that the social organizing of policymaking extends to and depends on community-based organizations with their local network of actors. These linkages create sites of policymaking outside the institution and demonstrate how ruling relations are textually extended to extra-local sites. It further affirms the important role that peripheral sites play in producing policy-related knowledge.

Another standpoint participant described the importance of these local peripheral sites as forming the cyclical link between the fund, knowledge production, and evidence production to support the organizations to succeed:

> "So, what we wanted to do with the fund was trying to look at this a little bit more closely and see how we can create a more enabling environment or supportive environment as a funder. We've done a couple of things and one of them is bolstering our knowledge, like our knowledge production and ways of knowing and opening that up and making sure that funded projects, feel supported and have the resources needed to take the knowledge that they're learning about the determinants of health and giving that to the policymakers who need that information to make evidence-informed policies at whatever jurisdictional level they're looking at."

The above quotation links the funding function to community sites where policies, programs, and innovations are implemented and gives community partnerships relevance in HE/SDH policy work. These sites also produce knowledge that influences the generation of evidence. As the standpoint participant stated, the evidence generated from these processes influences policies at various sites.

Figure 5. 4 The Cyclical text-guided process through which evidence is produced in policymaking as work



My impression of the cyclical process through which the institution funds enable communities to implement policies, programs, and innovation to address underlying SDH while producing knowledge and creating evidence that feeds HE considerations in health policy.

5.4.2.2 Encouraging Innovative Approaches

The standpoint participant noticed that in these iterations, there has been an emphasis on "innovation." In the various texts that I analyzed, "innovation" was used to hook the functions of PHAC or the roles of its leaders towards the private sector role in health policy. The funds made available were always labeled as innovation funds. One standpoint participant made this observation:

> "I mean we've been going for a while now, our last iteration was called the innovation strategy, and our newest iteration is called the Mental Health Promotion Innovation Fund, where our model was kind of narrowed down to focus on mental health, with the new incoming administrator or the current administration's emphasis on investment in mental health promotion."

From the above quotation, one can conclude that there has been a transition in language or terminology from "investments" to "innovation" in health. The preferred policy language in the Departmental Plans released during the years of Conservative government in power was "investment" in health. This signifies an invitation to the private sector and corporate indulgence to find solutions to inequalities through the market structure. The term was later changed to "innovation" in the post-Conservative government departmental texts to mean incorporating multi-sectoral players such as the corporate/business community in the policy process.

5.4.2.3 Universality as Guiding Principle

The universality guiding principle is applied to ensure that various community-based organizations are involved in implementing policies, programs, and innovations. The standpoint participant emphasized this in the quote below:

> "So, we have some experience and mental health promotion, but we also have experience in wider health promotion including food security. The way that we work is we fund that term think globally and act locally. That's what we do. We find different organizations across Canada, so that they can implement interventions, but also with an eye to underlying determinants of health which means often policy change, right, so that often means multi-sectorial policy change the ideas of health in all policies."

Universality as a principle surely helps organizations to access funds and to expand PHAC's reach across remote and at times hard to reach locations. The challenge to this principle is the lack of capacity of potential recipient organizations in some remote locations. The lack of

capacity could mean failure to meet the criteria for the available funds even when the need for service exists in those local communities. The lever for inequities in accessing government funding is usually the grant conditions and rigid accountability mechanism. It could also mean failure to absorb the funds once accessed, which could bring about accountability problems. The above conditions could imply that certain organizations in certain locations, such as in Indigenous settlements, may get disqualified and denied funding. Thus, the universality principle must be treated with caution because of its unintended consequences which could be alienating to communities.

In the above section, I described the social organization of policymaking as work. I presented the Annual Departmental Plan as the governing text that socially organizes policymaking at the centers and divisions of PHAC. I confirmed the guiding principle that organizes policymaking as work and offers insights into everyday activities performed by the standpoint participants in policymaking for HE possible. The section described how funding communities extend the ruling relations beyond the institutional sites and create important sites for HE policies, programs, and innovation to be implemented and evaluated. Such activities also hook the work of policymakers to the work of others at the local sites as they socially create knowledge, thereby aiding social production of knowledge and diffusion of evidence to make HE policy decisions. The standpoint participants are guided by the principle of universality which means that funding opportunities should be open and accessible by communities, so that local agencies that might lack the capacity to qualify, would not miss out on such ideal opportunities.

5.5 Policymaking in the Institutional Worksites

In this section, I turn my focus to discoveries about what happens within the institutional sites of policymaking, and how those happenings are experienced and influenced by the institutional characteristics, namely basic values, norms, values, and everyday order of doing things. My goal is simple – to present my findings of how the institutional character (Institutional character is an IE term that denotes values, norms, traditions, ordering, and so forth) and conceptual practices influence HE policy as work, and how other external influences bear upon HE/SDH concepts. This section is important because it illuminates the disjuncture – a concept in institutional ethnography which makes visible what is assumed to be happening in an institution and what is actually happening (D.E. Smith, 2005, 2006). A disjuncture links the standpoint participants to the problematic of the inquiry. By problematic, we mean identifiable tensions or contradictions that emerge from the standpoint of participants whose lived experiences are visibly coordinated and regulated by the institutions in which they work (Bisaillon, 2012; D.E. Smith, 1993).

5.5.1 The Policymakers are Qualified and Experienced

I found that the policymakers at the site of policymaking were highly experienced and qualified. The standpoint participants presented with both the desired academic training through universities in areas of SDH and HE at a master's, or doctorate level. Others are undergraduates prepared in health studies and HE/SDH fields. In addition to education, the participants had various experiences working in numerous policy areas such as social policy or worked as policy analysts for periods ranging from 3-30 years. Some of the standpoint participants accumulated their experience working within PHAC, outside of PHAC, in the National Collaborating Centre for Determinants of Health (NCCDH), with municipals, provincial/territorial, and federal health agencies, while others came from the private sector. Below are three examples from the quotes

from the interview that serve to capture and confirm the wide range of experiences of the standpoint participants.

> "I was reading a social policy and then I made my way to the federal position because my background (academic and work) was SDH and HE in Canada."

The standpoint participant clarifies her expectation when she transitioned from university to the workplace, hoping to "change things around". The confidence and hope for possibilities in the real world had enticed her to an institution that she felt was not doing enough to reduce inequities in health. Here is how she captured her motivation and enthusiasm:

> "After coming out of school and having studied social determinants of health I thought that, well I should work on fixing the problem, rather than being outside of the institution and telling them what they should do I should try to help that change so that is actually why I came into public policy."

Another standpoint participant had accumulated many years of work experience and demonstrated her qualification in public health sciences as follows:

> "I have worked at this Agency since 2011. I have a background of Master's in Public Health, with a focus on sexual health promotion. So, I joined the agency really with an interest in health promotion and disease prevention and addressing key inequities in key populations."

The standpoint participant's experiences and knowledge show that there is sufficient human capacity within the institution that could make the work on HE/SDH possible. Another standpoint participant identifies her work and locates herself within the division where HE and social determinants of health concepts shape their everyday work experience. Here is how she qualifies herself:

> "I started off working on the infectious disease prevention side and I've been working more exclusively in the area of social determinants of health and HE since 2017."

These individuals were not only educated and had gained considerable experience in their work within SDH, but they were also driven by passion and an urge to push the SDH agenda forward as exemplified by the following quotations:

> "I came into government actually because of the social determinants of health, because we know that policy and social policy, are the farthest upstream population health interventions, so if you want to influence change, then you should be working on government policy."

Another standpoint participant had a wide range of hands-on experience at an international health organization and hoped to bring the enthusiasm, expertise, and knowledge to share with this organization. Here is how she describes her journey:

> "I came to this position through a personal history of work in Health Policy at the international level with an international organization, I was offered a position with the public health agency, and I took it!"

Moreover, the participants acknowledged their sociopolitical consciousness that drives their working towards the distribution of SDH through the HE policy process. The standpoint participants acknowledged that their ideological orientation allowed them clarity, passion, and commitment to working for many years in pursuit of HE. Two quotations affirm the observation:

> "In my policymaking work as a policy analyst. I think that we really fall to the left end of the continuum. So, assuming that more of us identify individual-level factors like income, employment, working conditions and trying to target those specifically."

> "I think obviously. Personally, there are key more structural determinants that are essential in addressing and actually having an impact, whether that's, you know, increasing minimum wage income, housing, employment."

The importance of this rather long section is to demonstrate beyond reasonable doubt that the policymakers in charge of HE/SDH concepts are well qualified and grounded in HE/SDH concepts. They have experience, the will, and the right mindset to push forward HE/SDH concepts in the health policy agenda. Therefore, the failure of HE policy for action on SDH to filter in health policies cannot be attributed to the lack of knowledge and experience, or social and/or political consciousness of the policymakers.

The standpoint participants have the right academic qualifications, work experience, and appropriate socio-political theoretical orientations. Individually, they comprehend the current situation of social inequities in Canada quite well and expressed a desire to do something about it. During the interviews, the moment I pointed out gaps and lapses in the action on HE policy and the distribution of wealth in Canada, the standpoint participants readily acknowledged. They verbalized the urgency for equity policies towards redistribution of SDH but their body language or hesitation in their intonations signaled for me a sense of disjuncture. One would imagine that with this level of elite workers, policies on equity would be designed to be effective and clear enough to address socio-economic inequities that impact the health of Canadians. Also, the qualifications and experiences of policymakers combined would suggest that policymakers could advocate for HE and foreground concrete actions on SDH. But this has not been the case which then guides us to turn our gaze to explore other factors, rather than the issues of education, motivation, and experience.

5.5.2 Social Organization of Policymaking as Work.

One of the key tenets of IE is the understanding of what constitutes work, how that work is socially organized and coordinated within an institution (D.E. Smith 1987; 1999). However, such inquiries about work must begin from people's lives and actual work practices then move to institutional processes in which they participate (Prodinger & Turner, 2013). According to Smith, inquiry into institutions reveal multiple sites where intersecting work processes and courses of action occur. And by work, D.E. Smith (1987) alludes to "what people do, that requires some effort, that they mean to do (deliberate), and that which involves acquired competence" (D.E. Smith, 1987, p. 165).

Identifying the social organization of work is an important element of IE. D.E. Smith (1987) believes that work is socially organized and most of it is coordinated textually, from one point to another as we have seen in the previous sections. D.E. Smith further avers that at times, professionals may not be aware that what they do every day is work. And yet, they are engrossed in a complex social relation that recreates their actualities based on the activities that they perform, whether it is responding to an email, speaking with a colleague to clarify an issue or listening to an audio or visual recording from past training – all these everyday interactions with texts, discourses, discussions, and so forth, constitute work.

According to D.E. Smith (1999), people put together for one another a local historical organization of inter-subjectivity that transcends the immediate moments of their co-presence and goes beyond now in which every consciousness has a primary location. What people build in such a location, interlocks with what others build using the knowledge of how to do it as a means of explicating how it is done. The IE researcher then employs his/her expertise in identifying the methodological procedures for accomplishing activities to explicate it (D.E. Smith, 1999). In this section, I present discoveries of how policymakers experience and articulate their actualities of policymaking as socially organized.

5.5.2.1 Deconstructing Policymaking as Work at PHAC

Policy work or activities in the PHAC departments is hierarchically organized and routinized, vertically and horizontally, most of which is text-mediated and discursive. This finding confirms that policymaking is a complex multilevel process that cannot be pinned down to one action nor attributed to one actor or one location (K.E. Smith & Katikireddi, 2013). Several stakeholders come together, through a coordinated effort from multiple sites, to define a problem,

use evidence to identify potential solutions, and engage in knowledge exchanges to influence policy outcomes (Bergeron, 2018; Carey & Crammond, 2015; Sabatier & Weible, 2014).

In addition, these multiple complex activities take place in phases or stages involving planning, knowledge creation, implementation, and evaluation. Some processes may involve qualifying and disqualifying participants to policy, programs, and initiatives activities. Typically, Bergeron (2018) enumerates that the everyday work of a policymaker in the planning phase varies and could involve identifying, describing, and analyzing the problem at hand. Activities to achieve these goals could involve framing problems from different perspectives, conducting a situational assessment, writing briefing notes, drafting policy goals and objectives, and consulting with colleagues with expert knowledge. Furthermore, the work that a policymaker does could involve identifying and analyzing policy options from literature reviews, analyzing the policy options generated, and engaging in decision-making to identify which of the policy options to move forward with.

Another policymaker at another phase could be determining and understanding decision makers and influencers in this policy area. Concrete policy actions could be developing a list of decision makers and influencers, conducting a stakeholder analysis, prioritizing the order in which to engage decision makers and influencers. The policymakers could be assessing readiness for policy development – to ensure that the organization, the communities, and decision makers are ready to support the implementation of the new policy option or review other options. Concretely, the policymaker could be using the Policy Readiness Tool and even conducting a Force Field Analysis to identify the equilibrium destabilizing forces (Bergeron, 2018). The policymakers could be developing an action plan to guide the process of implementing a specific policy option. They could also be creating logic models to identify strategies, developing an action plan, or conducting

a HE Implementation Assessment (HEIA) on the action plan and doing revisions to ensure equity considerations and to evaluate the planning phase for readiness.

At the implementation phase, the everyday concrete work that a policymaker in that institution could do is developing and implementing the action plan. Here, the policymaker grapples with how to identify the social environment, cultural, economic, and political circumstances to adjust components of the policy being implemented or presented. Concrete actions could be consulting with those impacted by the implementation, developing progress reports, updating the action plan, and communicating changes made to stakeholders and the authorities (accountability). The next phase of facilitating the adoption and implementation of the policy involves engaging both decision makers and the stakeholders for policy uptake. Concrete action identified involves understanding the process of policy implementation, writing the policy in detail, communicating the policy, and most certainly, evaluating and communicating the evaluation results (Bergeron, 2018). (See Public Health Ontario, 2018)[16].

This daily work is not laid down in a particular order, rather it depends on the phase of the project, the priorities driven by politics and high order demands, or pressures owing to the end of the fiscal year when reports must be completed. These activities reveal the social organization of policy work, and all those processes are nested with a document – text that is produced for and from the process in the form of procedures, performance indicators, performance outcomes, accountability measures, and activities supporting resources such as posters, handouts, FAQs, etc. The standpoint participants also identified meetings, including staff meetings within their divisional worksites, and one-on-one meetings with their supervisors or managers.

[16] Bergeron, K. (2018). Supporting the policy-making process: A work tool. Ontario Agency for the Health Protection and Promotion (Public Health Ontario). Toronto, ON: Queen's Printer for Ontario.

In describing how the standpoint participant transformed and repositioned the understanding of equity from targeting the disadvantaged to closing the gap through action, here is how the work being done was described:

Interviewer: Describe for me concretely what you do to transition the understanding of equity from targeting the disadvantaged to closing the gap.

Standpoint Participant: "…to go back to my conversation about targeting the disadvantage versus closing the gap, that box like that piece of equity where you give the shortest kids the most boxes. That is targeting the disadvantage. So, it's an equitable solution, unless you get a kid who is even shorter next time, or you get a groundskeeper or the arena keeper who decides, I really need a box for something else (resource allocation). And then, someone has to go without a box."

Here, we see that the standpoint participant is demonstrating a theoretical foundation of knowledge in regard to the limitations of the existing HE frameworks. The standpoint participant further explained her work like this:

> "So, that is not as sustainable as we would like it to be. Like the equity solution that's presented there doesn't always help. That is targeting the disadvantaged. So, in our graphic, we've added a third piece, and that third piece replaces the bleacher or that wall around the field that they're trying to look over. We are replacing that wall with a very tall glass piece, and we call it removing barriers at the system's level, so that way it really doesn't matter how tall you are. You can still see the game, and you're still safe, and it

> doesn't matter how short the next person is that comes in, you can still see the game and you're still safe, and it doesn't matter if the arena keeper decides to reallocate those boxes because everybody can see the game and they're still safe."

Here, the standpoint participant demonstrates the amount of work needed to change institutional perspectives on health equity which the department realizes to be inadequate. The person works collaboratively across departments, with the managers, people in graphic designs, content experts, and so forth, to redesign a poster[17] that communicates the current understanding of equity as it should be, across Canada.

While executing the described routine work, the people involved in policy work are expected to coordinate and collaborate within the departments, with external agencies, businesses, not-for-profit community-based agencies, and so forth. The purpose of this collaboration is to leverage resources and provide funding for the stakeholders to implement or evaluate a policy or encourage and stimulate innovative approaches to remove socio-economic barriers. These pieces of work are guided by principles of universality in a way that access to funds for community interventions and programming is distributed equitably. Emphasis on equity at this micro-level policy work may generally be problematic. The hesitance in the perspective of the standpoint participant towards prospects of achieving HE in policy is an indication that the institutional environment may not be aligned to embrace systems change. HE and SDH concepts should, in the interest of this thesis, be the corpus of health policy work. However, the above sequence of

[17] PHAC (2020). Mental Health Promotion Innovation Fund: Equality Vs. Equity. Retrieved for illustrative purposes only from https://www.canada.ca/en/public-health/services/funding-opportunities/mental-health-promotion-innovation-fund.html.

activities describes the social relations that are eminent in the worksites where policy work is conducted without a commitment to systems change.

In policy theory, these complex institutional processes and actions are presented narrowly as a policy cycle, represented in a very simplified version of a logic flow of discrete well-defined procession of events. In real-life situations, these processes are murky and messy. However, engaging in these processes highlights how policymaking as work is socially organized. Thus, health policy outcomes are negotiated outcomes of social relations inherent in the concerted effort of many policymakers from various sites' work. D.E. Smith distinguishes between social relations in sociology from that used by Karl Marx and also adopted by Institutional ethnography. According to D.E. Smith, social relations used in sociology refers to abstracted forms of normative structures held to link positions or roles (D.E. Smith, 1990). D.E. Smith draws her concept of social relations from Marx's theories which refers to the actual coordinated activities of the actual people in which the phenomenon of political economy arises (D.E. Smith, 1990). The description of work thus entails the coordinated or articulated processes of action among persons taking place in time and place with a determinate form. The outstanding characteristic of social relations is that they are sequences that no one individual completes (ibid).

5.5.2.2 The Conceptions of Political Will in HE/SDH Policymaking

Every institution has its culture, tradition, norms, rules, and regulations. D.E. Smith (1997) identifies these as relations of ruling, most of which are textually mediated. Within the PHAC institution, policymakers are expected to construct their identities to conform to these rules, regulations, norms, and values. Group conformity may even define a measure of social competence.

The standpoint participants' experience of everyday work is organized within an institutional environment that is socio-politically conscious. Such an environment has permitted their worksites to exert themselves quite deliberately on HE/SDH issues. Some of the standpoint participants' experiences speak to a liberating environment where policy work is open to broad approaches when addressing SDH. This was validated by one of the standpoint participant's observations that the department's goals and activities are built around SDH and HE. Here is what was said:

> "I think in my work, I bet you the first one you mentioned in terms of different approaches, and we take a broad, broad approach and consider multiple social determinants of health. So, there's not one area that we exclusively focus on."

Additionally, the participants acknowledged that there is great leverage of political goodwill to permit local and trans-local collaborations. The participant explains that the political will is guided by the institutional mandate rooted in the Public Health Agency Act, 2006. These quotes exemplify the claim that a great political will encourages inter-departmental collaborations that mediate the work on HE policy for actions on SDH.

> "There are lots of different interdepartmental working groups. So that could be at, you know, the working level usually, or that could be at a higher level to senior management table, like a director or above were essentially representatives or the head of each department will meet and discuss these key issues related to a specific strategy or related issue."

The standpoint participant identifies a caveat in the inter-departmental collaboration taking place more at a higher decision-making level of the organization. This higher level may also represent politically sensitive locations. Below is an example where an inter-departmental collaboration happened with great success:

> "A good example of that is for problematic substance use. There was a deputy minister level table. The head of every department would meet regularly, to discuss essentially the ongoing opioid crisis. They discuss what are the key understanding, what are the issues? And what approach do we want to take and go with an opportunity for all departments to be engaged on the cross-cutting issue, and identify, you know, what kind of evidence, what resources about programs are in place, and what were the gaps that were needed to be filled?"

One of the indicators of inter-departmental collaboration is predicated on a strong political will, without which it is not possible. Often, politics get stirred when external forces mount pressures on politicians to act or account for an issue. Such moments are advantageous for policymakers because they always get things done within the institution. This is how the standpoint participant summarized experiences:

> "When there are interdepartmental groups like that, you know then that there is a stronger [political] pressure and will, and I think expectations that everyone plays a part, and everyone is accountable. That is when things move fast."

Another standpoint participant enumerated the importance of informal inter-department collaborations taking place. Such activities create opportunities for developing personal connections which ease future or subsequent collaborations. There are also formal inter-agency platforms to share information and insights. This is how a participant stated their experience:

> "In our day-to-day work, we obviously have working-level connections. I mean, I have been contacted by different departments. I can just pick up the phone or email the question. But then there is this more kind of formal working group or committees that we all are represented on, and we share information through those tables."

From the above quotations, we see that there is a degree of internal collaborations that occur. In IE, we analyze those as local and intra-local coordination which are governed by the ruling relations. These activities are hooked on a purpose, goal, and quest for certain information, knowledge or evidence. As such, these coordinated activities constitute legitimate institutional work that is often not well-validated or articulated. Extra-local collaborations, on the other hand, seem highly politically motivated, very rare, and occur higher in the bureaucracy. Inter-departmental collaborations are valued as facilitating work and creating avenues where inter-personal relations develop to build the ground for future collaborations on policy programs and innovations. This section confirms that there is sufficient expressed political will within the PHAC as an institution to promote collaborative work on advancing HE/SDH concepts in policymaking. We can, therefore, partially exclude suspicion of lack of explicit political will as an explanatory factor for the institutional failure to advance HE/SDH concepts into the health policy agenda as it should have been the case.

5.5.2.3 Locating the Ruling Relations

In IE, ruling relations are social relations that organize work from afar (Rankin, 2017; D.E. Smith, 1990). In the IE context, this concept is derived from Marx's analysis of class oppression of the nineteenth century, although these relations now are increasingly textual and text-mediated (Deveau, 2008). Texts play a key role in IE in that it is the bridge between the local context and broader or extra-local contexts. These explain how decisions made in one place gets conveyed and made alive by the action of people in another location (Rudrum, 2016; Smith 2006). Ruling relations are generated at a distance from a "standpoint" and "activated" in a local setting, and guide how work at the standpoint must proceed and how the work must be presented (Rankin, 2017). The ruling relations are usually textually-mediated. For instance, the Act, 2006 – the document that conveys the functions of the PHAC – carries the mandate of the CPHO, the term of service, remuneration, the kind of annual reporting required, the timing when such a report is to be delivered to the Minister of Health, where it should be delivered and coordinated, including the content of that report, are all specified in the text of the legislation.

This text shapes the conduct, the understanding, and what constitutes work for the office-bearer in the position of CPHO, the president, and so forth. D.E. Smith (2010) called these boss or governing texts situated at the top of the hierarchy of text. Boss texts are authorized through institutional procedures through which specific people are instructed to carry out specific practices. The boss texts coordinate organization relations so that how people work is controlled in conformity with the elective requirements of the boss text (Bisaillon, 2012). If the mandate letter is the boss text, the Act is the higher-level text which establishes the frames and concepts that control and shape lower levels texts in the institution (D.E. Smith, 2005).

During the interviews, the MML, the PHAC Act, and the Departmental Plan were the most mentioned texts. In the policymaking process, the role of text and textually-coordinated relations of the ruling are quite visible. The Act lays down the mandate and functions of the PHAC and its top bureaucrats namely the CPHO and the President. Standpoint participants made references to the "mandate" – the institution's mandate to focus on SDH. This mandate comes from the Minister of Health as the Annual Departmental Plan and is translated into divisional plans with set goals, funding, actions, and measurement indicators. The standpoint participants are then mandated to operationalize these activities to generate the desired departmental results. These sequences of events are increasingly textually-coordinated, which affirms IE's perspective on a text that once activated by a reader, becomes powerful in its ability to transcend time and place (D.E. Smith, 1990). These documents carry a certain language of power that gets activated at the local sites to determine what needs to be done, when, how, and why. The following quotations highlight the recognition of the ruling relations and to some extent explain the social organization of the work as the participants understood it, from their standpoint:

> "We're all guided by our mandate. So, something like ending poverty for us in the public health agencies, the only in our center specifically, the only mechanism that we have to do that is by either funding community program, or, you know, doing social innovation partnerships"

The standpoint participant understood the mandate in these documents and appreciated that these documents are explicit in their mission to promote HE concepts. This is how she summarised it:

> "In terms of our primary focus for promoting HE, we will differ based on which center or division you're looking at. In my division, social determinants of health are focal. Right now, our main focus is on the mental health of Canadians which actually has 'to promote HE' in the title."

It appears that the departmental name such as "Social Determinants of Health Division" should be specifying the departmental focus and the kind of work expected of it. Often this is not the case due to the narrow institutional approach to SDH. The standpoint participants turn their gazes to the public health's top professional namely the CPHO, Agency President, and Health Minister for guidance and inspiration. Below is what was said:

> "So that takes up the majority of what we have the capacity to do because it just takes so much work… But we get our focus from the chief public health officer from our Minister of Health and the President of our organization."

The standpoint participants confirmed that institutional interactions from top to the bottom of the organization happen textually. They identified some of the texts as follows:

> "I think we have more internal-facing documents, whether they're the mandate letters from Minister of Health, whether their statements for chief public health officer or, you know, our departmental plans that kind of we use that language and that approach to help guide our work."

During the interviews, whenever a text was mentioned or whenever the standpoint participant invoked a reference to a guiding text, they confirmed the nature of the text-dependent social organization of policymaking. Further, policymaking produced outputs that are measured and captured textually and electronically, in the form of reports, "evidence presentation", briefing notes, presentations, memos, recommendations, knowledge translation pieces, and so forth. Each of these texts is produced in one location and has a bearing at another location, meaning even if produced at the federal level, it will be influential at the provincial and municipal levels. Its influence may influence the activities of numerous external partners such as community agencies and international organizations, some of which are recipients of funding from the organization. An example of such texts may include COVID-19 Prevention Guidelines, such as how to quarantine or isolate at home.

Further, it emerged from the outside that the ministerial mandate letters carry a lot of political weight because they guide and dictate the direction of health policy activities. Another text whose relations of the ruling are prominent is the Departmental Plan. Each year, the Minister releases the Departmental Plan that when activated in its form, results in the release of funds from the treasury and coordinating those funds to community agencies. It's important to link the ministerial mandate letter to the Departmental Plan. The Departmental Plan determines the budget for policy activities and is also a tool to understand the government's policy priority. Thus, the Departmental Plan is a tool that the Health Minister uses to connect her mandate to action on health policies.

The standpoint participants noted that each Health Minister comes in office with a new mandate letter detailing their mission, power, duties, priorities, and expectations. It is these

expectations that gets translated into the policy action plans and conveyed textually to the various institutional sites of policy work. One participant stated:

> "So, the Minister's letter comes every time a new Minister of Health is appointed to that position. So, for example, every time that the Prime Minister shuffles the cabinet Ministers, they will reissue a new mandate letter specific to the person holding up position outlining the priorities and commitments."

The Health Minister's mandate letter conveys or transmits the government's policy priorities, however, it does not recommend specific actions on HE/SDH. It is the Minister to work with her associates in a way that priorities become part of the Departmental Plan. One standpoint participant stated in this regard:

> "The Minister of Health mandate letter does not explicitly mention the social determinants of health. But, certainly, in reading through it and our interpretation of what that means for our work it is clear. I mean, using language such as commitment to promoting diversity multiculturalism or you know addressing family violence. So, I think a lot of, without explicitly saying, social determinants of health, a lot of the actual mandate, or commitment or work that is passed to the Minister and our department, does directly address or aim to address key determinants of health."

In the above quotation, the standpoint participant demonstrates experience and intuition in interpreting the requirements of the HMML. Such connections that persons with the experience of

interest have with high-order texts constitute ruling relation. The ruling relations in policymaking work remain highly textual as Deveau (2008) acknowledges that in today's economy text-based forms of knowledge and discursive organizations have a heightened role in shaping people's everyday lives. Additionally, it reveals how people's everyday experiences are hooked into and coordinated by ruling relations (Deveau, 2008). Having analyzed the various key institutional texts that shape the social organization of work on HE/SDH concepts in the organization, I conclude that the lack of explicit mention of HE/SDH in the various texts partially explains the ambiguities with which these concepts are understood and interpreted within the institution. The ambiguity or lack of commitment to these concepts as highlighted in the Health Minister's mandate letter does not allow for a common interpretation of actions to implement them. Zahariadis (2008) referred to such circumstances as typical of a policymaking environment shrouded with ambiguities. We can, therefore, partially begin to put up a case that ambiguities from the lack of explicit directive on how to act on SDH partly explain the lackadaisical response that the institution affords HE/SDH concepts.

5.5.2.4 Institutional Conceptual Practices (of Power)

Institution conceptual practices play an important role in identifying institutional ideological character. D.E. Smith's (1990) idea of conceptual practices of power emphasizes the materiality of ideology manifested in texts, and how ideological methods of operating participate in producing ruling relations (D.E. Smith, 1990; Stanley, 2018). Thus, within these complex institutional worksites, what constitutes facts are analyzed as the result of institutionalized working practices. In understanding how ideology leads to objectification, D.E. Smith (1990) argues that the materiality of ideology is itself produced through a method that centers on canceling out the

subject within an institutional apparatus which utilizes these approaches. Thus, the objectification of knowledge produces factual accounts of different kinds, known ordinarily as records, statistics, news, data, databases, files, and more.

During the interviews, the standpoint participants revealed that there are two ways of doing work for HE policy within this institution. One of the approaches is when the directives come from the political circle at the top and are framed textually as a government priority. This usually reflects the ruling regime's ideology about health, most of which filters through the HML. The second approach is through external pressures on the political leaders. When the PM is caught up in politicking with pressure groups or civil society organizations, s/he may issue a policy directive in response to the pressure. The response to the political pressure from the external groups influences policy prioritizing when the government finds money to fund these groups. A good example of such a program is the Mental Health of Black Canadians Fund which was inspired by leaders of the Black communities, but also by 2016 Advancing the Mental Health Strategy for Canada: A framework for Action. In this document, the Mental Health Commission of Canada recognized the role of mental well-being on SDH, such as precarious housing, poverty, social exclusion, and racism. It further recognized that Black Canadians were the most impacted by significant social and economic challenges with negative implications for their mental health (Government of Canada, 2021). [18]

In IE, ideology is a form of knowledge that is uprooted and ungrounded from the social circumstances in which it is produced (Bisaillon, 2012). Rankin (2017) observes that ideas that circulate in the "authoritative" discourse are understood to arise "ideologically" from inside the

[18] Government of Canada (2021). The Promoting HE: mental Health of Black Canadians Fund. Retrieved on February 15, 2021 fom>https://www.canada.ca/en/public-health/services/funding-opportunities/grant-contribution-funding-opportunities/promoting-health-equity-mental-health-black-canadians-fund.html#a1

ruling ideas. D.E. Smith abstracted her understanding of ideology from Marxist conceptualization of social relations (Smith, 1987; 1990; 1999; 2005) and delineated what she meant by ideology as what is emerging from people's actualities, the work they do, and the social relations inherent in that work. In line with this testimony, one of the standpoint participants stated, thus:

> "When we're mandated to do something, we're told that you need to do an act or work on this new program, well then, we need to make it fit within a HE framework. And so, it might look a little a bit different. Whereas, if we were to design something from the ground up. We might have more of a chance to design that along in line with our understanding of HE. But at the same time, there's a lot to consider so I don't know whether that is a conflict per se."

This quotation reflected a moment of disjuncture because the realization by the standpoint participant reveals a conflict in expectations. The implication is that when the directive to perform an act comes from above, meaning a politically loaded priority, then the person working on a particular HE policy has to find a way to fit such a demand into an existing equity framework. Sometimes such a quick fix does not work out and reduces the depth and quality of the outcomes. Such directives may also significantly derail a previously planned policy action. Whether such directives fit neatly or shabbily within an existing matrix of policy work remains contested, however, the standpoint participants found that such a directive is very disruptive. It appears that fitting such a priority into the equity framework to meet a political objective takes precedence over a legitimate process of testing, tweaking, and applying the standard "best practice" or evidence-

based concept that is preferred as the gold standard in texts that we have seen before. Another standpoint participant affirmed the disruptive nature of this practice as follows:

> "You're carrying out the mandate of the government of the day. And, so, it is often a priority at the highest level of decision-making and that would be coming from the Prime Minister's office or a Cabinet Committee. It is very disruptive, but you must comply"

The above quotation demonstrates how institutional hierarchy and bureaucracy transmits the political and ideological outlooks through the health policymaking process as work that is embedded within an institution (Bradshaw, 2003; Coburn, 2010). The top-down structure becomes disruptive to progress on work on health equity when emerging political priorities are allowed to filter down to override or displace a focused work on HE. It also confirms that sometimes politics supersedes scientific evidence in the process of health policymaking. Additionally, it could imply that the institutional profile of HE/SDH issues is low on the priority list such to an extent where it is easily displaced. Health Equity work is sensitive to the politics of the day.

5.5.2.4 Unpacking the Ideological Character of the Institution

The policymaking process is generally sensitive to the politics of the day. PHAC as an institution is not immune to changes in the political environment when Canadians elect new leaders, or when reshuffling occurs within a governing party or a coalition lead to changes in the Health Minister. The standpoint participants observed that for HE policies to be linked to SDH, stability in the political environment is much needed. The most preferable socio-political environment is a stable progressive ideological orientation as experienced under the Liberal party

when compared to Conservatives. In the latter case, the disruption to HE policy work becomes quite dramatic, especially with the Conservative government or a Conservative-leaning Health Minister. One standpoint participant demonstrated this challenge as follows:

> "We don't have any control over the ministerial reshuffling, or how often these Ministers get changed, but generally speaking, even if it's, [pause], I mean, as long as the same political party stays in power like under the Liberals the overall essence in terms of commitments and priorities or demands stays the same."

However, the standpoint participants acknowledged that ministerial reshufflings at times become too frequent owing to changes in national leadership or pressures on a ruling party. These changes have both direct and indirect effects on the institutional focus and commitment to the work that they do on HE. In contrast, the standpoint participants attested that there was less destabilization in two circumstances; one being when the reshuffling happens within the same party in power (intraparty) as opposed to when an election ushers in a new government with a different ideology. One standpoint participant had this to say:

> "Where we sometimes see bigger shifts is when there's a change in leadership, so if we were to go from maybe Liberal to NDP or the Conservative government, likely there would be a shift in what we were prioritizing to work on."

The above quote demonstrates that achieving HE in health policy is sensitive to the political or ideological environment in which policy work on HE/SDH occurs. The most important

conclusion here is that achieving HE through policy requires a stable and progressive political environment. From this section, it is most likely for HE policy work to gain traction and climb onto the policy priority agenda under any other socio-political formation than the Conservatives. The standpoint participants recognized that working on policies that promote equity in health is harder and at times sabotaged under a Conservative regime. This is in part because the Canadian Conservative government considers the free market the central institution of society as we shall see more at the provincial level (Hunter & Milofsky, 2007)[19].

5.5.2.5 Local to Extra-local Coordination of Policymaking Work.

The "local" in IE refers to the circumstances of the immediate and interactional settings where people live, work, and research (Bisaillon, 2012). Thus, the local becomes the basis of an analytical focus to explicate how what occurs in the immediate environment is connected with and shaped by what happens elsewhere (D.E. Smith, 1987). In this section, I locate the local, where the standpoint participant is located, and trace how their work is coordinated through complex textual processes.

According to Bisaillon (2012), IE concerns itself with tracing what happens at the local and what happens in extra-or trans-local places far away from the local. The local is specifically what roots people's experiences of social relations including textually-mediated relations of ruling (DE. Smith, 2005; Stanley, 2018). D.E. Smith maintains that "the everyday world is not fully understandable within its scope. It is organized by social relations not fully apparent in it nor contained in it" (D.E. Smith, 1987, p. 92). To explicate people's actualities, D.E. Smith guides that

[19] Hunter A., Milofsky C. (2007) The Conservative View: Markets, Inequality, and Social Efficiency. In: Pragmatic Liberalism. Palgrave Macmillan, New York.

the extra-local can be mapped by proceeding from the actualities of the everyday world because the social relations external to the everyday experiences are present in its organization (D.E. Smith, 2005; Stanley, 2018). And "their traces are to be found in the way that people speak about their everyday lives" (1987, p.188), Here, D.E. Smith encourages IE researchers to map the local to the extra-local through the textually-mediated activities where the ruling relations manifest and come to bear.

In attempting to explicate what the standpoint informants do and the kind of work they do, many activities were described and summarised as follows: once they receive their iterations, the policymaker also receives a file describing details of their assignment. Some assignments are short-term, 3-5 years, while others are long-term, up to ten years. Depending on what portfolio the policymaker has taken, they are expected to produce texts from words such as supervision and accountability plans, preparing a call for funding, receiving, and processing funding application, reviewing departmental policy documents, writing reports, attending training, developing tools, resources, and networking with partners both internally and externally. All these work or engagements are deliberate with a mandate arising from either their job descriptions or from the requirement based on a certain section of a higher-level document in their possession that requires activation. The goal is to help others within the government and externally to better understand and apply the SDH and HE as one of the standpoint participants stated:

> "We do a lot of capacity building. So, both internally and externally developing tools, resources, training, to help others within government and externally again to better apply and understand the social determinants of health and HE and data we do that through partnering with a variety of partners, internal and external to government. And a lot of the

work we do also focuses on the total partnership of partnering outside of the health sector on key determinants of health."

"The capacity building, we do, I guess, currently, and in the past have been more offered like in-person for public servants and kind of related stakeholders. And so we've done Indigenous cultural competency training or currently developing a training pilot program focused on racial equity so specifically anti-racism training. And so, I think a lot of the need for this training stems from our work and the specific files we work on. But the broader interest and need for developing capacity across different stakeholders and the work we do."

From the description of the staff capacity building, the standpoint participant makes a case that their staff is properly trained about factors that disadvantage people. The training is in line with orientated staff about groups to be targeted for interventions. There is some work going on to build capacity within the institution around Indigenous health, SDH, and anti-racism. The education being coordinated locally, however, bears on sites outside the institution and cannot make a lot of sense for HE policy until such skills are applied in decisions to produce, HE policy recommendations addressing those structural barriers. Thus, an extended textually-mediated relations of ruling becomes visible when afforded a proper interpretive practice from within the institution such that it influences actions on SDH that change real people's lives for those situated outside of the institution.

There are several extra-local collaborations, described as, "working across federal government levels", with other federal agencies such as employment and social services, and

departments for housing. In identifying these activities, texts that define the ruling relations such as the Federal Strategies and Initiatives like the Federal Housing Strategy, the Federal Poverty Reduction Strategy were referenced (but not analyzed). One of the standpoint participants pointed this out when asked:

> "We are definitely, I guess, engaged in work at the federal government level such as the employment and Social Development Canada that is the department that is federally responsible for housing. Through federal strategies and initiatives such as the Federal Housing strategy, the Federal Poverty Reduction Strategy, we are engaged through like Interdepartmental Working Groups."

> "More externally, it depends, right, so this media division convened a meeting in Montreal on Health in all Policies (HiAP). And so, we invited federal and provincial representatives to talk about work that was ongoing in different regions. And as part of that, we had brought together with evidence of examples of Health in All Policies that we saw at the federal level in Canada to bear."

The two quotes above demonstrate the nature of collaborative work that happens at the institutional site, beginning from one institution and reaching out to another. This experience, however, is not uniform across the PHAC divisions and centres. Depending on which division and the portfolio the policymaker is working on, extra-local collaboration can happen or not. Below, are two quotations that demonstrate local and translocal collaborations on a policy issue:

> "So oftentimes when there are these federal strategies and initiatives, we are working closely with other government departments to feed into their strategies to make sure that we do address and take that like a more holistic approach. So, it's not done in isolation"

> "But I would say that all of our work is definitely complimentary, there would never be an issue where we were doing, you know, housing initiative or some sort of being kind of in isolation and not involving other departments. So, we, we have the components that we feed into a different department."

The above quotes demonstrate that some inter-governmental or cross-departmental collaborations actually occur. Such opportunities enhance knowledge sharing and dissemination through extra-local collaborations in platforms such as national conferences where existing policies and policy activities are brought forward. Extra-local coordination also allows for the diffusion of new knowledge, innovations, and greater discussion on emerging trends of social and health inequities. This collaboration helps to minimize departmental silos[20] prevalent in some government departments (Fenwish et al., 2009; Wolf-Fordham, 2020). The critical question that remained unanswered is under what circumstances do this intergovernmental inter-institutional and inter-textual interactions possible? How long do these collaborations last and to what ends do they serve?

In sum, the standpoint participant recognizes that trans-departmental collaborations are part of the institutional norm, and it is an expectation to build networks, share knowledge and learn

20 Fenwick, T., Seville. E, Brunsdon, D (2009) Reducing the Impact of Organisational Silos on Resilience. Resilient Organisations Research Programme: New Zealand

about innovations. Extra-local collaboration enables the dissemination of knowledge that is socially produced in one location to saturate and filter into prevailing ideas in another location. Through such collaborations, HE/SDH concepts may permeate dominant narratives and discourses in those locations. These ideas may even shape or reconstruct the conceptual practice of power within other institutional sites. By conceptual practice, D.E. Smith (1990) refers to the concrete or material practices in which people engage and highlight the social relations that connect them (cited in Bisaillon, 2012). According to Smith (1990; 1987), ideas and concepts are produced through the material practices that people engage in within an institution, organization, or settings where they live or work making inter-agency or trans-institutional collaborations; a great strategy for broadening the scope of policymaking to advance HE.

The main conclusion for this section is that policymakers are sharing their work with other partners, co-creating knowledge on how to act on HE/SDH concepts, and learning together through interactive platforms like conferences. This finding is important because it rules out the idea that maybe policymakers at PHAC have specific policymaking duties detached from others. The numerous opportunities to coordinate their work, knowledge, and experience with others, demonstrate that perhaps, HE/SDH concepts are being resisted even in other institutional sites or jurisdictions. It may also mean that other jurisdictions are aligned with the dominant narrow approach to health that fails to connect the link between HE/SDH concepts in their policies as we shall see.

5.5.2.6 Institutional Influence on Fulfillment of Policymaking as Work

In this section, my finding summarises whether or not policymakers have fulfillment in their policymaking roles as work in an institutional environment that resists HE/SDH concepts in

policies. The work that people do is not detached from their everyday/every-night experience of fulfillment at policymaking as work, or their actualities. D.E. Smith (2005) describes people's actualities as lived experiences that the standpoint person enumerates as knowing and living them and not separated from the same world in which the researcher is inquiring. According to McCoy (2008), people's actuality is a methodological term that orients analytical attention to "a world of things, activities, and experiences that includes, but is not coterminous with, texts and language" (p. 705).

The standpoint participants described their work as fulfilling because their daily work experiences was immersed in joint efforts at developing policies that promote HE for actions on SDH. The policymakers' understanding of success and advancing progressive ideas, however, depended on their colleagues or superiors – supervisors and managers. The policymakers felt that the orientation of the senior management team to HE/SDH concepts mattered when new ideas emerges and needed advancing, or where old ideas proved insufficient and needed suppressing. The standpoint participants recognized that their work outcomes were not absolute. Rather, they got validation when their portfolio reports, briefs, or recommendations met their colleague's and management's expectations. These are quotes from standpoint participants that highlight the importance of validation and understanding of progress as incremental in their work:

> "I think you know a good work date does not always mean agreement. I mean, I think it's just a matter of a better understanding to increase awareness and understanding of the broader context in which we work. Definitely, I mean a good workday like a success to me is being able to advance a certain idea or certain initiatives and get support from senior management on my end for projects for an issue that we feel is important."

> "I think, success can be looked at and interpreted in many different ways, but I think this collaboration and hearing that validation and feedback from others, whether it's internally or externally with our stakeholders that you know we are on the right path that we are focusing on the right areas, engaging the right people."

The quotes reflect optimism, but masks what D.E. Smith (1990) describes as conceptual practices of power. The concept reveals a sense of satisfaction that is embedded in discursive practices because people working in one site, always identify with the institutional narrative of satisfaction, competence, validation, and progress at that site. When standpoint participants begin to overcompensate by splitting the definition of success into different units, such a narrative becomes a pointer for concerns. Change within an institution, whether in attitude or policy position certainly has its triggers. Most of the time change is slow and unpredictable but may also be frustrating. Thus, for policymakers, one can appreciate how validation from the superiors could sustain efforts to promote HE-oriented health policies. This section is important because it demonstrates that policymakers feel a sense of fulfillment in their policymaking as work. Policymakers are doing their best at advancing HE policy recommendations and leaving decisions to their superiors as to whether these concepts are advanced beyond management.

5.5.2.7 Timing Matters When Advancing HE/SDH Concepts

The standpoint participants acknowledged that work on HE within the institution depends on good timing. Within the institution, HE policy work depends on its timing relative to the larger scheme of government operations. For instance, it is counterproductive to hold a prime discussion

of HE/SDH at the end of the fiscal year, budgeting time, CPHO reporting time, election time, or times of health emergency. The standpoint participant demonstrated this experience as follows:

> "I think there's always so many different considerations and factors, whether it's budget or, you know, timing. Timing is key to I mean right now. As the government, we work by fiscal year so as we approach the end of March, I think there's generally you know things are winding down and we're looking at measuring and evaluating and recording on the past year's work but there's very little that we can do in terms of new initiatives until we start the new fiscal year. So, I think just being mindful of the overall operating context."

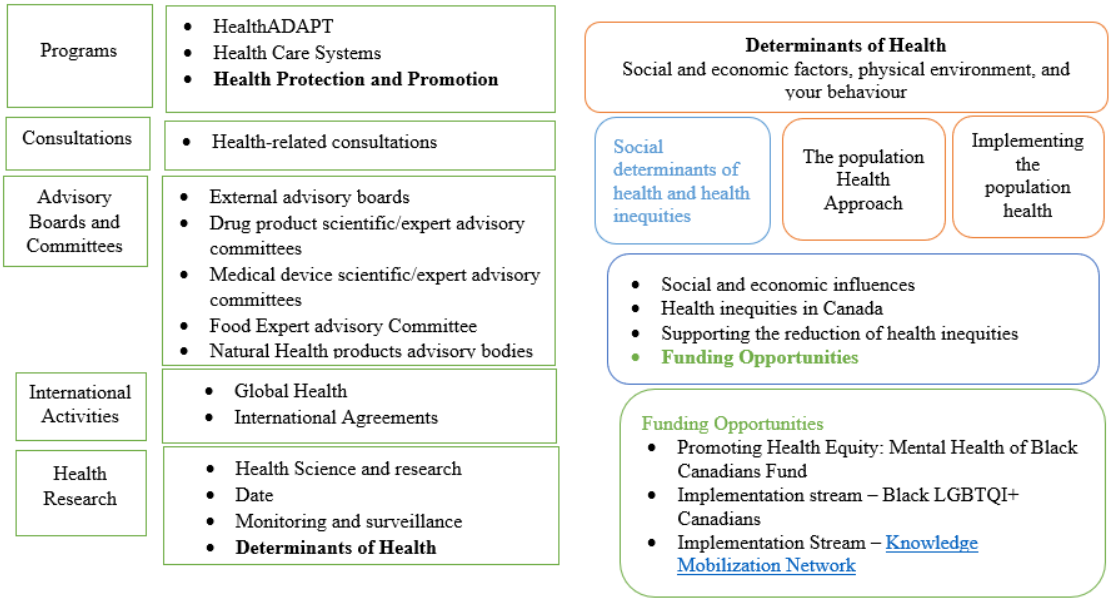
The above quote demonstrates the context in which activities that promote HE/SDH concepts in policy are constrained by certain events and the systems of government operations as a whole. This is important because it supports other findings that HE/SDH concepts are not on top of core responsibilities of public health functions. It may explain why these concepts are easily displaced or concealed when disruptions occur within or that which affect the public health system.

5.6 Institutional Considerations of SDH

This section pertains to institutional conceptual practices and consideration of HE/SDH but with a focus on SDH. The key questions I will be answering are both epistemological and ontological in IE. That is, how does the institution conceptualize SDH, and in return, how do the policymakers perceive the institutional commitment to health equity-oriented policymaking as work for actions on SDH. I discovered that both the institutional conceptualization and policymakers' everyday encounters shape discourses on health policy outcomes uniquely. Below,

I provide a schema of how various texts organize the work on health equity at institutional sites in PHAC. This is a simplified version of the pile of data that I gathered. The color variation is deliberate for easier decoding:

Table 5. 3 How Health Policymaking Activities are textually organized in Canada



5.6.1 SDH is Well-Articulated and Agreed - Upon as Important

According to the standpoint informants, SDH is well-articulated into the body fabric of the institutional everyday operations. One standpoint participant believes that their division operates from the textbook definition and contemporary understanding of HE and SDH. Moreover, the understanding of HE is also linked overtly to its social justice roots in this institutional location. The standpoint participants stated that:

> "So, we use the textbook definition of the places in which people work, are born grow, play... We use the WHO definitions or commonly used PHAC definitions, but what we have noticed is that the determinants of health as they are categorized changes quite a bit."

In the above quote, the standpoint participant demonstrates that the institution uses WHO's understanding of SDH, but also acknowledges that jurisdictions have different considerations of SDH. In Canada for instance, Indigenous heritage is considered an SDH. Another standpoint participant found that SDH concepts were well-understood and clearly-articulated both in discussions and in the various texts. It was observed, thus:

> "I think it is [SDH] quite articulated quite clearly in our division because we are so much driven by the 2008 WHO Commission's Report on SDOH. So, HE for us is the distribution of unfair, or avoidable health outcomes. And I guess I guess one difference, might be, how we talk about it and then how we use it. So, we do have these broad and very socially just definitions of HE."

The above quote confirms further that there is a standardized textual understanding of SDH within the institution. Another standpoint participant observed that there is a commitment to the SDH across the entire Canadian health portfolio. The standpoint participant believes that the government is very committed to promoting actions on SDH. To her, SDH as a concept is widely shared and discussed, and accepted as a legitimate object of health policy. Below is what was stated:

> "I think the health portfolio in Canada is pretty committed to SDH and hosted conferences, including the Ottawa charter, conference, population health conference, and commitment to social determinants, like our declaration will be also established the Canadian Council on Social Determinants of Health to support Monique visions and she was Commissioner for the WHO Commission on Social Determinants of Health and in fact has done quite a lot, and reporting is already going on."

The above quotations demonstrate that depending on a site of policymaking as work, policymakers may be exposed differently to the SDH concept. However, the fact that the standpoint participants in this location are hooked to a text-based and universal understanding of, and interactive with SDH, is an indication that there are opportunities within the institution to advance the concept in health policy.

5.6.2 SDH Requires a Long-Term Commitment

The standpoint participants recognized that work on SDH generally requires a long-term commitment as results may take time and demand a lot of work to become visible. In most of their descriptions, the standpoint participants identified work arrangements that stretch from a minimum iteration of three years to somewhere between five and ten years for results or evidence of success to materialize. Some of the standpoint participants demonstrated that the work on HE and SDH are quite challenging owing to several factors that shall be elaborated subsequently. In addition, the standpoint participants stated that it is difficult to get conclusive evidence of effectiveness or lack thereof in the first iteration of testing or implementing a policy, as it requires patience,

funding, and continuous work on the policy. The following quotation represents these sentiments that SDH of health work requires a protracted time to evaluate its outcome:

> "…you know their work on the social determinants of health coming to fruition that's going to take a couple of years. It takes a long time. So, we know that there are a couple of things we have to do included in the work to promote HE and health and social determinants. And it's been difficult, it's been a really challenging piece to program."

The standpoint participant estimates that in order to develop a good HE policy that is sensitive to SDH concepts, work is needed in back-and-forth negotiations, testing, integrating new evidence, dropping old thinking, and so forth. These activities could last a decade or more. Here is an example of a long-term work that a standpoint participant provided:

> "It was difficult to get that information in the first iteration and keeping in mind that if it ended in 2019 that means it started in 2010, which means the planning for it happened in 2008, we're talking about, you know, a decade of information and knowledge that's happened along that time."

It is important to appreciate that the work on SDH is not an easy one when the mindset is not correct. The work even gets more complicated when other external interests such as politics and economic noises become more powerful. Either way, it is of the experience of the standpoint participants that within this institution, a good HE policy for redistribution of social and economic

resources could take up to a decade to develop. This is not any different from the timeframe taken for pharmaceutical companies to develop and patent a drug!

5.6.3 Variations in the Acceptance of SDH Concept

While standpoint participants in one site of policymaking may socialize with SDH concepts elaborately, others do not. The variations in the acceptance of SDH concepts within the institution unveil a disjuncture in the subjective experience of some standpoint participants with SDH concepts within the institutional sites of policymaking. Despite this elaborate understanding and consensus on the relevance and the urgency of SDH within the institution, and in the policymaking work, the study found variations in how the concept is institutionally internalized at different sites.

The approach to SDH is based on an institution-wide practice that recommends managing inequities in health by addressing individual-level factors. This is opposed to applying an upstream approach through HE policies. The latter would mean coordinating policies that would increase the building of affordable homes, schools and school experiences, as well as committing to the basic minimum guaranteed income, universal childcare, universal Pharmacare, etc., and addressing imbalances in the allocation of power and resources. Rather, these departments may take action simply to be seen to act with a sense of equity, which may include co-opting certain disadvantaged groups into the established institutional (governmental) HE/SDH frameworks or addressing individual-level coping mechanisms. One standpoint participant pointed this out this way:

> "And we didn't have a ton of time to do that, we didn't have a lot of money to do that actually we didn't have any money as scientists, but you know it was important for us to take that moment. And we decided that one piece of that was also to open up our definition

of determinants of health and our categories of determinants of health to include, for to at least be open enough to also include the determinants of health frameworks from the First Nations community."

The statement above demonstrates where the institution says one thing and chooses alternative action. An example of an institutional tradition where Indigenous people's unique experiences and circumstances were broadly recognized in SDH discussions sufficed. However, none of the Indigenous frameworks ever made it to the official government reports. This paternalistic institutional practice implies that the concerns over Indigenous people's exclusion would be resolved by co-opting the Indigenous well-being continuum framework into the institutional SDH mainstream discussion. Below the standpoint participant reiterates her experience with the continued exclusion of the First Nations people in health policy:

"The First Nations mental well-being continuum framework has earned three Association of First Nations' awards; I think it is the association of First Nations. And they have a framework for social determinants. And we wanted to be able to easily include it in the way that we work, and so do it with the ICK which is the Inuit's community. They also have determinants of health and work mostly to mention, but they do talk about social determinants of health."

The insight from the above discussion is that many disadvantaged groups may have their categories of determinants of health. However, the institution has its specific interpretation and standard frameworks that constitute its understanding of, and action on SDH. The disjuncture is

experienced when such consideration of SDH becomes problematic and further alienates the disadvantaged groups that government interventions are intended for.

5.6.4 Variations in Interpretation and Commitment to SDH within the Institution

While SDH is well articulated and seems to be well understood within certain institutional locations of policymaking at PHAC, there exist institutional variations in the way SDH concept is actually interpreted and applied in everyday practices. Some standpoint participants revealed that variations in understanding or conceptualization of SDH pervade the entire institutional sites of health policymaking. Although standpoint participants agreed that SDH is widely acknowledged and promoted as a policy objective, not everyone in a position of power within the institution actually understood the concepts well. These are mostly bureaucrats and decision makers whose experiences and qualifications may be outside the scope of the "scientists" working on SDH-related policies, programs, and initiatives. This concern has implications for the incongruences with which HE runs shorts of its social and economic mediating expectations. One standpoint participant reflected on her personal experience upon entering one site of policymaking as a new employee as follows:

> "Advancing SDH was the work that I was used to doing. So, when I started talking about HE and social determinants of health from those perspectives and I got a lot of blank stares."

Another standpoint participant reiterated a similar experience at work with leaders within the department and within institutional sites:

> "When I first came into this program, they said you were working on the social determinants of health and that was my area. So, that's where I went, and I was excited about it. And I asked, so which determinants of health are we working on? Like what are we doing, and no one knew!"

The lack of a unified understanding of SDH seems deep and rampant among other staff as well. Although this offers an opportunity to educate those actors about SDH, it may also undermine progress when those without buy-in have the decision-making powers. Below is what another standpoint participant stated:

> "They view that [SDH] as more upstream, and so it's not a challenge but there's certainly differences of interpretation, but for my mental health colleagues, for example, they wanted to know exactly what social determinants of health are.

The fact that institutional decision makers in positions of power such as managers and supervisors within such an institution remain ambivalent about SDH is daunting enough. Another challenge in the institutional consideration of SDH, however, is in the variation or lack of harmony in conceptualizing what constitutes an upstream approach in health policy discourse which easily promotes and sustains the narrow focus on HE policy (Rutter et al., 2017; Watt, 2007). Thus, the standpoint participants observed the following:

> "We don't all share the same definition of upstream. So, an upstream intervention can be interpreted very differently, so those of us who work more from the lens of structural determinants."

The confusion further arises from a lack of unified understanding of what upstream measures in public health are. One standpoint participant had this to say:

> "We think of upstream interventions maybe as, you know. To be policy change or broad population interventions, versus others who may think of something happening within a community delivered by a program to individuals who will then help their families."

These quotes demonstrate a discrepancy in the understanding of the fundamentals of SDH and it may affect how health policy and more specifically, health policy equity is conceptualized. In part, this discovery is the best pointer, within the institutional influences, that may explain concerns that SDH scholars have identified as a blatant lack of commitment or even governmental incompetence in addressing SDH through equity health policy (Bryant, Raphael, Schrecker, & Labonte, 2010; Raphael, Komakech, Bryant, & Torrence, 2019; Raphael, Curry-Stevens, & Bryant, 2008a).

5.6.5 The Ubiquitously Narrow Focus on HE/SDH

Importantly, the narrow focus on HE/SDH remains pervasive within the institutional sites of policy work and that undermines progressive work on SDH. The standpoint participants

acknowledged their struggles with moving away from personal or individual focus to a broader approach, looking at SDH as the new future of public policy (Bryant, 2016; Raphael et al, 2019). The quotes below captured this juxtaposition of the frustration among standpoint participants at the extent of the institutionally narrow focus on SDH. Here is how a standpoint participants summarized their experience with the pervasiveness of the lifestyle approach:

> "That's how I met John [not real names] who actually extended his list of determinants that I used for reviewing his categorization, for the most part, just to see what we were funding. Like just to see what the projects were doing. And, without the oversight and the knowledge about how to program the social determinants of health, some of them were sticking squarely into behavior, which was considered a determinant of health until recently. Like personal health practices and coping skills, was listed as a determinant of health on the Public Health website until just recently. It might even still be. I don't know […] the kind of the culture of personal individual responsibility permeates the work around the social determinants of health."

The institutional focus on individual attributes, such as personal coping skills and personal health practices, seems well-entrenched as another standpoint participant elaborated below:

> "What I would say more on this issue [individualism] is what you get at when you're talking about social determinants [of health]. So, if you want to know that the lifestyle drift is quite prevalent, you talk to people about broad structural things, and it still comes back

to; Okay, let's tackle healthy eating or while physical activity is doing the same thing, and it's kind of missing the concept."

The quotations above demonstrate that the institutional conceptual practices are not exclusive of the focus on the individual, which I found to be ubiquitous within the institution. The narrow focus does not look at the broader approaches to SDH concepts which action on SDH and situate it within the societal upstream levels where imbalances in the distribution of power and resources are addressed, using equity-driven public policies (Raphael, et al., 2019; Bryant, 2016).

5.6.6 The Socio-Positivist Hegemony

In this section, I make the case for the existence of a particular form of intuitional hegemony by analyzing the ideological character of the office of the current CPHO. Much of the finding here arises from studying information available on the PHAC website in combination with analysis of other related texts. The discovery is complemented by studying CPHO's reports. I found that as a gatekeeper to HE/SDH concepts in this institution, scrutinizing her practices, beliefs, and values as stated publicly, can help us foreground the dominant institutional conceptual practices of power rooted firmly in the socio-positive hegemony. The adherence to biomedical paradigms privileging individual health behaviour change and approaches targeting a population of need as defining equity-focused HE policy formulation, may explain the inability of HE/SDH concepts to explicitly filter through into health policy.

The textual analysis of the CPHO's beliefs and practices for the person entrusted with the mandate to oversee public health in Canada, demonstrated that leaders in this organization lack a

dedicated focus on the SDH concept beyond the narrow focus. The CPHO's vision statement posted on the PHAC website is explicit on her commitment to SDH concepts. Below, is how it is stated:

> "I will champion the reduction of health disparities in key populations in Canada so that the poorest and most marginalized among us have a chance to lead healthy lives, both physically and mentally. I am committed to working with all of our partners, to support science and research to provide the best evidence to inform our actions, and to engage with Canadians, especially those with lived experience." (Government of Canada, 2019).

In the above extract, the CPHO commits to reducing "disparities" among the "marginalized" by using "the best evidence" and "engaging those, especially with lived experiences". I found the total of the language to convey the biomedical hegemony. First, the phrase "disparity" is used in positivist language to mean differences between categories or groups and is devoid of the ethical imperative to act on these differences in the sense health equity would require (Braveman & Guskin, 2003). The proclivity for best evidence buttresses positivism and the focus on those with lived experience is ambiguous; but it implicitly implies a focus on individualist approaches.

The CPHO works in collaboration with the President of PHAC to execute three roles: a) exercise public health leadership as Canada's top public health leader; b) communicate significant health issues using the unique voice and various means and channels associated with this office; and c) encourage and lead innovative partnerships and actions. The CPHO is the most empowered

civil servant in her field with powers to communicate, collaborate and coordinate across divisions and departments. Furthermore, the CPHO is quite explicit in her understanding of SDH as laid down on her website – at least as it is written. In her vision statement, she strikes the non-committal word "disparities" commonly used in the US to evade taking actions on health inequalities (Braveman & Guskin, 2003).

On her website[21], the CPHO sets the tone for targeting the disadvantaged, which is the traditional conceptual practice of the institution (Government of Canada 2019). The CPHO further observes that many of Canada's most pressing public health issues are complex and significantly impacted by stigma and social factors such as education, income, housing, and accessible and affordable foods. The CPHO demonstrates a commitment that addressing health inequities can only happen by addressing their social determinants. To further cement her vision as rooted in SDH concepts, the CPHO stated, and I quote inter alia:

> "…social determinants of health, such as income, have a bigger impact on our health outcomes than genetics, the health care system, or most health care services."

Additionally, the CPHO pledges to raise awareness and commits to act as a catalyst for action on factors influencing health, which she lists as: income, education, social environment, physical environment, social support networks, sex and gender, healthy child development, and culture (Government of Canada 2019). The above statements of commitment sound as if Canada

21 Government of Canada (2019). Dr. Theresa Tam: Vision and Areas of focus. Public Health Agency of Canada: Retrieved from https://www.canada.ca/en/public-health/corporate/organizational-structure/canada-chief-public-health-officer/statements-chief-public-health-officer/health-equity-approach.html

currently has the most progressive CPHO on issues of HE/SDH. However, that is as far as her declaration of commitment to the HE/SDH concept goes.

On further scrutiny of the CPHO's main practice interests, the study discovered that the CPHO's priority areas of work are listed as Cannabis, Opioids, and Alcohol with a view that these are "factors for the prevention of problematic substance and; reducing stigma and discrimination." (Government of Canada, 2019). The CPHO's second area of focus is Healthy Children and Youths, aiming at providing Canadian children with the best start to life through promoting breastfeeding, physical activity, positive mental health, and immunizations. Her third area of focus is sexually-transmitted diseases and blood-borne infections, where she engages partners to increase awareness and education.

The fourth area of focus is anti-microbial resistance, where again her approach is to collaborate with partners to increase awareness, prevention, and education. Finally, her fifth area of interest is a healthy-built environment where she works in collaboration with stakeholders to help make healthier choices easy for people through improved availability of active transportation, accessibility to healthy foods, and supportive environments (Government of Canada, 2019). While the CPHO is explicit on her knowledge, will, and commitment to advance SDH concepts, at least on paper as demonstrated in her vision statement, her practice areas are steeped in mid-stream practices as opposed to upstream practices. The Ottawa 1986 Charter for Health Promotion justified the shift for public health focus away from individual risk factors and behaviours towards the social conditions that keep people healthy. The importance of social, economic, and

environmental determinants of health was further heralded in the WHO Commission for SDH report in 2008 (Kickbush, 2003[22]: Baum, 2008[23])

The best explanation to place the CPHO's approach, and by extension, the institutional conceptual practice of power is captured by Aggleton (1990) when he described these practices as a social-positivist's approach of explaining and responding to health issues.

Social positivists are those who explain health or lack thereof as linked to the social context in which people live. According to Aggleton, there are three variations is social-positivists: a) those that emphasize the lifestyle explanation to health such as dietary, smoking, and physical activities; b) those that focus on cultural influences, thereby explaining health or lack thereof as contingent upon certain cultural attributes such as ignorance, recklessness, and pure fecklessness (Aggleton, 1990; Shah, 2003); and c) those that identify environmental determinants such as built environment, improvement in technology, transportation and so forth.

The three streams of social-positive explanations of health embraced the practices and values of the current CPHO. In looking at the priority areas of focus of the CPHO, this study concludes that the leadership of PHAC and the institution as a whole, practice the social positivist approaches to health promotion on the health, and corporate management practices on the other. This observation is important because it exposes the fact that the institutional leaders have a narrow focus on SDH, which is an individualist approach. Such approaches come at the expense of broader SDH such as class, ethnicity, sex, age, disability, immigrant status, gender, social inclusion, and culture (Aggleton, 1990). This finding is particularly important because it is grounding us to an explanation of HE/SDH concepts not filtering into health policy from this institution's perspective.

[22] Kickbusch I. The contribution of the World Health Organization to a new public health and health promotion. Am J Public Health 2003;93(3):383-8

[23] Baum F. The Commission on the Social Determinants of Health: reinventing health promotion for the twentyfirst century? Critical Public Health 2008;18(4):457-66

5.7 Institutional Conceptualization of HE

In this section, I provide discoveries into the institutional conceptualization of the HE concept in health policymaking. The reason for splitting the section into conceptions of HE and SDH is to enable a more detailed focus on how the two concepts do or don't attract specific attention, and whether or not HE is more visible than SDH in the conceptual practices and conceptualization within the institution.

5.7.1 HE in Perspective: Unveiling the Invisible

In this section, I focus on explicating the concept of HE as it is understood, promoted, discussed, mediated, or resisted during work processes as organized by the Annual Department Plan in this institution. First, I observed that HE is a well sought-after goal of health policy work across the institution, but this work is made visible in the departments. Inconceivably, there is no one unified understanding among the standpoint participants of HE in the various departments as we shall unveil gradually.

Due to the anticipation that equity considerations would be high on the policymaking agenda, the study found a lack of clear political guidance on the pursuit of HE in policy work. I will provide insights into equity frameworks and tools to demonstrate that targeting the disadvantage is the mainstay of much of the equity work that the so-called "scientifically produced evidence" supports at the programs, policies, and initiatives levels. Individualist approach leads biomedical approach. In the US, the clinical and public health approaches for promoting healthy behaviours is rooted in the fact that rational agents freely choose particular actions or object of consumption and thus the individual has designated the locus of change (Goldberg, 2012).

To contextualize the institution-wide high proclivity for HE, and to further unpack how this concept becomes simultaneously visible and invisible in these institutional worksites, we need to focus first on texts and textually-mediated social relations. Many active texts shape work processes in various worksites within the organization and constitute the ruling relations (D.E. Smith, 1987). In tracing the conceptualization of HE in policymaking as work, this section focuses on discoveries from analysis of the Departmental Plan.

5.7.2 HE in the Departmental Plan

Important aspects of the work on health policy and HE should be studied from documents that translate the stated government's HE/SDH commitment into policy actions. D.E. Smith (2003) highlights the role of text as the pathways through which social relations enter organizations. According to D.E. Smith (1987, 2003), departmental texts translate into textually-mediated forms of power that organize the everyday world of the standpoint participants and shape their relations to one another. D.E. Smith (2003), however, maintains that these pathways are not always obvious or explicit as we do not easily see how pervasive they are. Thus, by tracing these relations of ruling, we are able not only to ask what people do but also to ask what *do* people *do*? (D.E. Smith, 2003). It is the work that people do that hooks them (the standpoint participants) to the organization of power. Thus, the documents that they produce through these processes embody what Smith called "objectified consciousness." (D.E. Smith, 2003; p.31). By "objectified consciousness," D.E. Smith (2003) offers a critique of science's sharp division between people's experiential knowledge and the objectified and authoritative knowledge espoused among professionals, scientific communities, and academics. D.E. Smith maintains that, historically, the subjective experience or experiential knowledge of women in the everyday work that they do is not recognized as knowledge (D.E. Smith, 2003).

As Mykhalovskiy and McCoy observe that IE grew out of this discovery of the rupture between what women were familiar with as lived experiences, and the forms of social expressions in the mainstream sociological discursive (Mykhalovskiy & McCoy, 2002). Thus, the idea that decision-making should pursue objective scientific evidence negates the subjective knowledge of the policymakers that accrues over time. The demand for objective scientific evidence as valid knowledge is not only limiting but offers insights into happenings or the kind of challenges for HE/SDH concepts in the various departments as I shall show.

The Departmental Plan is an annual forecast of performance of a department over three years that the Health Minister tables in Parliament every spring. This plan reiterates and affirms priority action areas and at times it may define or redefine the works on a particular policy, program, or innovation to address emerging health priorities. The Departmental Plan is also aligned to the sitting government's health action plans, and it is a work plan that guides the Minister to achieve her mission as stipulated in the Minister's mandate letter. I have described the authority of this document in coordinating and socially organizing work in departmental worksites. Take, for instance, the 2020-21 Departmental Plan's stated government-wide health priorities which are growth for the middle class; open and transparent government; a clean environment and a strong economy; recognizing diversity as Canada's strength; and promoting security and opportunity for Canadians. In contrast, the 2021-22 Departmental Plan focuses on government-wide priorities derived from the 2020 Speech from the Throne. It listed the following priority areas; protecting Canadians from COVID-19; helping Canadians through the Pandemic; building back and better – a resilient agenda for the middle class and; valuing the "Canada we are fighting for" (PHAC, 2020)

Compared to the Departmental Plan 2019-2020 which did not mention HE at all; and 2020-2021 which explicitly mentioned HE twice (once about promoting the mental health of Black

Canadians and another time in affirming the GBA+ as PHAC and the government of Canada's commitment to HE), the 2021-2022 Departmental Plan focuses on health promotion and chronic disease prevention, and mentions HE explicitly nine times. It has a section that describes the pursuit of HE as an agency-wide responsibility. The Plan is drawn from the CPHO's 2020 Annual Report which acknowledges the impact of COVID-19 in exposing and amplifying existing health and social inequities in Canada. It further affirms that the inequities that COVID-19 exposed demonstrate a growing gap between public health, social and economic systems necessitating the whole-of-government responses to COVID-19. The government's response to COVID-19 is presented as heading towards achieving health-in-all-policies approaches.

The 2021-22 Departmental Plan recognizes further that reducing health inequities is actually a core function of public health and a cross-cutting component of PHAC's mission and mandate. It sets forth three targeted goals: a) enhancing the development and uptake of HE data and evidence in decision-making; b) integrating HE considerations into policies and programs; and c) cross-governmental collaboration to address SDH that is at the root of ill health and health inequities (PHAC, 2021). The Departmental Plan further commits itself to ensure the funded program adopts an HE lens, by applying the SGBA+ and this hooks onto Sustainable Development Plan Goal (SDG) 3: Good Health and Well-being.

In the table below, I demonstrate, how scanty Health Equity appears in institutional discourse especially in the key documents that frame policies and programs at PHAC. I analyzed the departmental plans from 2018 – 2022 in which I searched for "Health Equity" or "Health Inequities" for visibility in those texts as a primer for institutional dialogue to promote action on SDH. Below I show a quick word count to demonstrate how scanty HE appears in previous Departmental Plans and then becomes visible in 2021-2022 amidst the COVID-19 Pandemic.

Table 5. 4 Frequency of explicit recognition of HE or inequities in PHAC's Departmental Plans over time.

Departmental Plans by year of release	Explicit Mention of HE	Explicit Mention of Health Inequities
2021-2022	9	0
2020-2021	2	0
2019-2020	0	0
2018-2019	0	1

The implication of the lack of implicit mentioning of HE in policy work has an impact on how the HE concept is interpreted or conceived by the standpoint participant as we shall see in the next section.

The above section is important because it traces health equity concepts in the Annual Departmental Plan and demonstrates that HE concepts are not often explicitly mentioned in the ADP. However, the ADP plan released in the pandemic year was explicit on HE and made it visible as a health policy goal to address inequities exposed by the pandemic. Overall, the policymakers who are hooked onto the ADP have the opportunity and privileges to interpret aspects of their work as work that requires incorporating and advancing HE in policies, actions, and innovations.

5.8 Policymakers' Subjective Experience with HE/SDH Concepts

In this section, I report discoveries from the subjective experiences of the policymakers within the institution, and how that experience influences HE policymaking. Ranking (2017b) emphasizes the relevance of describing how ruling and social relations within an institution

coordinate what people in the standpoint do. Thus, this section represents findings from the standpoint participants' accounts of how the institution works with and around HE, thereby shaping their everyday experiences with HE concepts.

5.8.1 Varied Conceptions of HE

The standpoint participants identified that there is no unified conceptualization of HE despite the concept itself being very popular and on-demand as a health policy goal across the numerous institutional worksites. Some policymakers understand the term HE as an approach that can be applied to programs and others use it as a lens through which they design access to policies, programs, and innovations. One standpoint participant demonstrated like this:

> "…what's important isn't necessarily the categories of determinants for us, because we've recently also been looking at ourselves from a perspective of HE. And so, our nine years of work finished in 2019 and we launched our new solicitation [..] for a fund in 2019, and we've just started it now. And one of the things we wanted to do is make sure that we were actually catering to Canadians, and we wanted to take that HE approach and look at ourselves very quickly."

This group understands that the use of HE as an "approach" to program designs and evaluations as opposed to a "lens", implies embedding HE actions in the processes of their policies, programs, and innovation as one standpoint participant clarified:

> "I know at the agency we definitely use both kinds of language (lens and approach), in my experience, the approach is more. I don't want to say formal but the approach definitely speaks more to the process. A Lens, I think lens to me is kind of like, look over, you know, make sure things are considered."

The above quote depicts the ambiguity that prevails within the institution when considering the HE concepts, and it prevents the HE/SDH concepts from gaining a consistent and dominant presence during the policymaking work. The lack of a unified conceptualization is confirmed in text and now in discursive such that ambiguity in discourse is applied as a tool to suppress HE concepts in policy work.

5.8.2 HE as an Outcome

Other policymakers view HE as an outcome achieved by leveling the playing field. Additionally, the standpoint participants' reference to institutional texts/documents that describe "moving towards HE" is another way of affirming that deliberate work is being done with HE as an outcome of policymaking. The quotations below exemplify some standpoint participants' subjective experiences with the iterative nature of HE within the institution:

> "I do think that HE is an outcome, but the outcome is almost of the process itself, because you'll note in a lot of our documents, we talk about moving towards achieving HE."

> "And so really, I think it's about understanding that we can somehow level the playing field or level opportunities to act on social determinants. So, I would agree that [HE] it's an outcome."

The standpoint participants here demonstrate a sophisticated understanding of the HE concepts and demonstrate that when used as a measure of outcomes, health policies designed with an equity concept allow action on SDH to reduce social and health inequities. From the above testimonies, one can conclude that some clarity is needed on how the institution should apply HE concepts. There exists, however, ambiguity in the use of HE concepts across institutional sites, and this ambiguity filters through institutional sites of health policymaking. To demonstrate a more practical approach to using HE as a measure of policy outcomes, one standpoint participant observes that measurements of outcomes and its indicators during policy or program evaluation are associated with reducing health inequity, therefore the way you know that one has achieved HE is by indication of a decline in health inequalities. This was elucidated, and I quote:

> "On the other hand, we do [institution] commonly look at social determinants of health and HE measures of outcomes you mentioned, so, in our kind of the Departmental Performance Reporting measurement evaluation, we do have specific indicators that we measure that is related to reducing health inequities."

The prevailing lack of consistency over what constitutes HE pervades the institution. HE is viewed in various ways, and this may be driving top decision makers to fail to grasp the concept and disadvantage it from reports and/or discussions. After carefully engaging with multiple

conceptualizations of HE in this institution, I concluded that the lack of consensus on the concept is deliberate. It is part of the institutional conceptual practices, otherwise, a working definition and term of references should have been developed and enforced within institutional sites.

5.8.3 HE as Targeting the Disadvantaged

Another theme that emerged was that HE actions are steps taken to target the disadvantaged population as the main and preferred institutional approach. The standpoint participants identified several programs that target the disadvantaged and explained how these programs are structured around a specific at-risk population and extend to addressing individual diseases, conditions, or behaviours. Thus, funded programs are named after at-risk populations and policymakers develop criteria for eligibility for accessing community-based or regional-based funding according to such targeted descriptors. One standpoint participant clarified in this way:

> "Right now, when you talk about programming at the funding level, as a funder, most programs talk about funding and HE in a way of targeting the disadvantage."

The work on HE targeting the disadvantage is itself focused on demonstrating an acknowledgment of inequities that may be localized within a particular population group. Another standpoint participant provided another example from a common institutional understanding of HE actions as being valuable when policies are designed to target the disadvantage for action on SDH. The example is as follow:

> "…to go back to my conversation about targeting the disadvantage versus closing the gap that box like that piece of equity where you give the shortest kids the most boxes. That is targeting the disadvantage. So, it's an equitable solution, unless you get a kid who is even shorter next time, or you get groundskeeper or the arena keeper who decides, I really need a box for something else to resource allocation. And then, someone has to go without a box"

Indeed, several programs and policy actions at PHAC target a section of the population. For instance, a list of multi-year funded programs include "Black mental health", " mental health of children, youths and their caregivers", " improving the well-being for Canadians affected by autism spectrum disorder", and so forth (PHAC, 2020). Policymakers believe that targeting the disadvantage is an outdated approach towards HE because it has not worked. Therefore, a new approach is needed to close gaps between the well-off and the disadvantaged.

5.8.4 HE Should Focus on Closing the Gap

Another theme that emerged from the data is the movement or consideration of HE as an effort at closing the gap between the well-off and the disadvantaged section of the population. Closing the gap is seen as a more progressive approach and it may run against the institutional current practices. The policymakers promoting this idea are unsure of institutional buy-in, however, their work with the closing the gap concept has been tolerated and afforded space to evolve. The standpoint participants exemplified an understanding of the link between health and socio-economic inequalities as that which cannot be harmonized by targeting a disadvantaged

population. This group is more recent, charismatic, and argues that HE is viewed among them as actions that are best taken towards closing the health gap (Graham, 2004, 2007).

The group has done significant work in amplifying the difference between equality, and removing barriers in action. One example of their work is modifying the graphic which shows kids standing on boxes to peek over the bleacher fence so they could watch a baseball game. In this graphic, equality means offering all the kids, irrespective of their height the same box size/height to stand on; while equity is portrayed in the same graphic as ensuring that the shortest kid gets the highest box to be able to see the game behind the fence. The closing gap group believes that such a systemic approach to obtaining equity in health policy is unsustainable and wastes resources. By closing the gap approach, the group developed a new graphic that removes the wooden fence and replaces it with a glass wall. The kids no longer require boxes. This way, the glass reduces the gap between the advantaged and disadvantaged kids. One standpoint participant stated:

> "So, in our graphic, we've added a third piece, and that third piece replaces the bleacher or the wall that they're trying to look over, with a very tall glass piece, and we call it removing barriers at the system's level. So, that way, it really doesn't matter how tall you are, you can still see the game, and you're still safe. It doesn't matter how short the next person is that comes in, they can still see the game and you're still safe, and it doesn't matter if the arena keeper decides to reallocate those boxes because everybody can see the game and they're still safe."

By removing the boxes, which represent resources, the standpoint participant argued that such valuable resources could be reallocated to areas where it is most needed. Closing the gap

approach may be the most progressive, even representing a paradigm shift in approach. Nonetheless, the approach is still focused on individual-level intervention to address systemic and socio-economic inequities. These longstanding social inequities are inherently political and embedded with contestation over power and resource distribution in society (Coburn & Coburn, 2007; Coburn, 2001; Raphael, Curry-Stevens, & Bryant, 2008).

5.8.5 HE is Hard to Communicate

It emerged from the data that HE was hard to communicate within the institution. While some institutional actors viewed the HE concept as part of their work, they argue that the HE concept is intangible, multidimensional, hard to measure, and therefore hard to justify as a course of legitimate action or a cause to be funded. One standpoint participant explained it as follows:

> "At the most, HE concept is puzzling, not tangible, multidimensional and situation based; hard to measure; hard to justify it for funding."

Another standpoint participant expressed frustration with the confusion in the ubiquitous use of the concept in institutional language. The participant saw the popular acceptance of HE within the institution as merely a performed act to justify fundings. The quote below represents this viewpoint more succinctly.

> "In terms of the determinants, I mean, they're all there and it might just be language that we use, could be more specific. I think it's a needless distinction, other than from the vantage point of making sure we funnel dollars into it."

The lack of system-wide conceptual clarification or definition of HE makes communicating HE challenging in an environment that privileges scientific evidence over experiential or authoritative evidence. The lack of an explicit definition of HE at a political level may partly have bred this ambiguity that makes communicating HE convincingly difficult during policymaking as work.

5.8.6 HE Is Hard to Measure

The challenge of producing evidence in this institution is to use a measurement method that is reliable, dependable, and acceptable in the biomedical field as done by epidemiologists. HE and SDH concepts, however, are touted as hard to measure. This idea is problematic for the standpoint participants because it complicates presenting the concept convincingly. One standpoint participant demonstrated this challenge as follows:

> "It's relatively new right now so I've been by myself along with two of my colleagues. We've been really tackling this HE piece, like a piece of the jigsaw puzzle that is difficult. It's hard to hold on to as it's not tangible, and it's different for every single population that you work with, right. So, it's a difficult one, it's hard to measure and measurement is a mainstay in programming. And if you can't measure it, it's hard to prove that you should do it. So that's where that emphasis on system change comes from."

Another standpoint participant identified this measurement challenge but stated that in their department, there are performance reporting measurements embedded in the evaluation tools. How

they navigate away from HE discussions is by inserting indicators that are related to reducing health inequities, in their tools. This is how she summarized her everyday work experience:

> "On the other hand, we do commonly look at social determinants of health and HE measures of outcomes you mentioned so in our kind of the departmental Performance Reporting measurement evaluation, we do have specific indicators that we measure that is related to reducing health inequities."

From the above quote, it appears that it is much easier to measure and operationalize reducing health inequities than seeking HE policy through existing institutional mechanisms. However, the conceptualization of HE as hard to measure masks the institutional resistance to addressing HE as a requirement of social justice. This also contradicts the institutionally popularized notion that HE is a priority for health policy goals.

5.8.7 HE is Visible at Community-Level Work

The theme of HE in process of policy or program implementation at the community level emerged frequently. This theme reaffirms the linkage between the HE concept and the various toolkits developed to enhance the absorption of HE measures (Porroche-Escudero & Popay, 2020; Williams et al., 2016). There are several toolkits developed from within the institution and in collaboration with external partners such as the NCCDH. These toolkits reinforce the design of community-based programs that embed HE in its implementation as one of the indicators of success.

Ironic to the persistent lack of HE experiences among Canadians, the tools that public health practitioners use to assess their programs for HE impact are numerous. A 2016 University of Victoria's Equity Lens in Public Health Project created an inventory of HE tools. These tools were found to help assess how well HE was integrated into public health policy and programs; to measure the health impact of such equity-focused policies and programs; and to promote the inclusion of HE in public health policies and programs (Pauly, MacDonald, Hancock, et al., 2016). Public health programs include those that promote social inclusion, mental health, and so forth. These toolkits also shape the design of funding opportunities for community organizations which are sites where policies and programs are tested for their effectiveness. The standpoint participants demonstrated the usefulness of the equity toolkits as follows:

> "…as we go through the process to think about things [during programs planning], we may not have necessarily thought about equity when working with these communities or providing support, and just building in the importance of cultural safety. Even in the funding process and different things like that so I'd say equity exists, but the toolkits make it imperative."

The above quote demonstrates that policymakers may need a cue to action to remember to include health equity consideration into their programs. This revelation is key because it affirms the lack of institutionalized focus on HE and the laxity with which policymakers easily forget or exclude health equity from their policies, programs, and innovations.

5.8.8 Delinking HE from Social Justice

The lack of a unified institutional stance on HE makes accountability for the concept difficult. One standpoint participant observed that HE is deliberately not linked to its cognate of social justice. Within the institution, social justice is rejected overtly on the account that it is rather an activist and not bureaucratic nor a scientific idea. The standpoint participant observed:

> "The moment you link equity to social justice, they reject it because you're speaking activists' language, instead of scientific or bureaucratic language".

The above quotation demonstrates the deliberate institutional distortion of health equity and affirms an early finding that politicians and bureaucrats are in a position to tolerate HE debate as long as it is delinked from its social justice cognate. As such, they find it convenient to reduce HE to access, rather than a moral imperative to prevent the growing gap in health experiences between people. It appears then that work on HE lacks the political commitment to move it forward and this may explain the ambiguity with which it is communicated in government texts and institutional discourses.

In the above-concluded section, I presented emergent trends that demonstrated the policymaker's subjective work experiences in understanding how the institution has situated HE in its discursive, texts and conceptual practices. Arguably, the institutional norms, practices, and values have a profound bearing on the legitimation of policymaking as work to advance HE for actions on SDH and therefore shapes the way these concepts are articulated, acted upon, discussed during policymaking as work and the kind of policy outcomes that are expected.

5.9 How the PHAC Institution Shapes Work on HE

In section 5.8, I presented discoveries from the subjective work experiences of the standpoint participants as they go about their policymaking work in the various institutional sites. Section 5.8 is different from section 5.9 in that this section presents discoveries of how the standpoint participants perceive the institutional work environment from their subjective standpoints. This effort may reveal further disjuncture and offer insight that may help to explain why HE/SDH concepts are not filtering through public policy as expected.

D.E. Smith (1987) has focused the attention of IE researchers on the work that people do and how they do that work within an institutional context. In IE, work is anything that requires intent, effort, and time; and yet this work also is the starting point to trace social relations in which the work is situated (D.E. Smith, 1999). IE directs us to the sequence of events in which people are engaged in multiple local settings and evolves through the coordination of people's actual activities (D.E. Smith 1999). It is through the assertion of their bodies in these activities that individuals' knowledge and experience are situated to explicate the relations that shape these experiences. Thus, the standpoint participants have demonstrated having elaborate work experiences and therefore have also developed their perceptions as to what does not make work on HE produce the expected impact.

5.9.1 SDH/HE Is a Temporary Feature of Public Health

Within the institution, the standpoint participants acknowledged that multiple interpretations of HE and SDH are a deliberate institutional practice. The persistent ambiguities around HE/SDH concepts mask actual policy goals and actions needed to achieve them. This ambiguity is also associated with SDH concepts seen as being fluid and pervasive and not a

permanent feature of public health. One standpoint participant explained their experience with ambiguities surrounding HE/SDH as follows:

> "There are different interpretations of the social determinants of health, there are different ideas of what are the social determinants of health. And if you think I've even been lost, maybe change is needed on that front as well."

This standpoint participant expresses how a policymaker in her position fails to understand what is being discussed as social determinants of health within the institution. This lack of coherence and consistency offers insights into the ambiguities that shrouds HE policy work. Another standpoint participant summarized succinctly the attitude afforded SDH and thus, HE within the institution:

> "I don't think there are static categories of SDH as we perhaps used to think, because what is an underlying determinant for one population could be a risk factor for another. It's about scale and magnitude, right."

While SDH may not be classified in static categories, this ambiguity is a strategy to delay work on HE policies. Otherwise, there is a consensus that social inequalities are widespread. Social inequalities become social inequities the moment these inequalities are unfair or unjust while modifiable (Braverman and Guskin, 2003; Marmot, 2008).

5.9.2 HE Is Communicated Using a Selective Use of Language

It emerged that within this institution, policymakers have to be deliberate and technical about the use of language owing to the political sensitivity of concepts that communicate change. For instance, the standpoint participants found it delicate to promote the idea of moving the HE agenda outside the favored tradition of targeting the disadvantage. However, communicating an alternative approach to reach a buy-in level requires careful use of language not to unsettle the base of the establishment. Often the standpoint participants felt that their ideas may not have an avenue or a platform to be heard, so they go ahead and just "do things" in the spirit of HE. One standpoint participant stated as follow:

> "When I want to talk about moving our HE agenda, outside of targeting a disadvantage. I talked about system change. For instance, I think the culture of risk aversion is not as cemented as a kid feels sometimes. I have thought about this before and gone ahead and just done things that I knew could be in the spirit of HE. And I've always been received really well at the end of it."

The lack of avenues to incubate, innovate and introduce alternative ideas to the prevailing risk-averse approach to individual health has often inspired subtle resistance within some policymakers. The standpoint participants realized that most times, management does not share a vision of moving away from traditional approaches of addressing social inequities. This includes some of the decision makers within top management who may have a very narrow understanding of HE as targeting the disadvantage and nothing else.

The institutional experience of the standpoint participants is such that their actions, narrated as "I have just gone ahead and done things" and "so I tend to just bulldoze through the noise"

exemplify a spirit of resistance to repressive institutional norms and traditions. The policymakers highlight situations where they can move the discussion on HE/SDH from process to outcomes or discuss alternative approaches towards achieving equity. The institutional actors and decision makers such as managers seem to accept the outcome from creative work which reveals a possibility for more progressive policymakers to cause the change in reimagining HE and SDH concepts within the institution. One standpoint participant recounted an experience with how words and concepts are used in this institution deliberately. The standpoint participant observed that on one accession, they chose to undermine the dominant targeting the disadvantaged language discursively and textually by excluding common descriptors such as "at-risk" population and "targeted" population. By choosing this course of action, the policymaker hoped to subvert the hegemony of targeting the disadvantage, although with much difficulty. The standpoint participant quickly realized how difficult it was to change this tradition due to its deep historical embeddedness within the institution, in public health bureaucracies, and within North American culture as a whole. This revelation emerged when the standpoint participant stated:

> "…a lot of that happens with wording right like I'm trying to move the conversation away from targeting the disadvantage only. So that means not using words like "at-risk" populations, or "target" audiences. And that's a hard nut to crack inside of this organization and bureaucracy. Public health bureaucracies align across North America because that's how they've spoken for decades. And it's been the politically attractive wording. Right. Ministers want to be able to get out there and say, yeah, we're doing this much for this, this population, but it undermines the work on equity."

Another way language is used to describe HE tactfully within the institution is population health language which has been problematized. The standpoint participants found that population health is used in the institution very narrowly. It is used in ways that undermine broader approaches to HE policy for the distribution of social and economic resources. One standpoint participant expressed their frustration with this experience in their everyday work:

> "Another example of the use of language is talking about population health. We use those words in the work that we do, and I often find that it can be too downward facing and too limited. Anyway, it ends up looking a lot like health-promoting interventions, as opposed to doing more broad aspects. And to me, it's more about the spirit of what we do. And we already know that that has to be rooted in the social determinants of health and HE and I'm not sure that population health is doing that, as much as they wanted."

The way language is used within the institution, both discursively and textually has shaped the experiences of the policymakers profoundly to make them suspicious of the institutional commitment to HE/SDH concepts. Most often, the language tended to shape and reinforce a narrow approach to HE work. The language tends to emphasize and circumnavigate around targeting the disadvantage and taking an individualist approach to policies that promote HE. The language used within the institution also cultivates multiple and often confusing meanings of what constitutes HE and actions on SDH across its numerous sites. These everyday experiences where a policymaker is constantly conflicted, the contradiction creates a disjuncture – the disconnections between people's experiences and knowledge of the world and the official or authoritative

representations of these (Bisaillon, 2012). This causes what D.E. Smith describes as a dissonance, a split or a rupture, in consciousness (D.E. Smith 1990).

5.9.3 Key Decision Makers Are Not Grounded in HE/SDH Concepts

Structurally, the PHAC is organized uniquely. For instance, the Center for Health Promotion is separated from the Social Determinants of Health Division. According to PHAC (2008), the Centre for Health Promotion (CHP) uses a life stage approach with policies and programs tailored to enhance the conditions that foster healthy development. It is driven by principles of population and public health to address determinants of health and facilitate movement through the life stages.

While these centers are separated from each other, both their conceptual practices target identified disadvantaged populations, which is the corpus of the work on policies that promote health equity at PHAC. Much of the Center's policies, programs, and innovations happen at community levels and do not entail strengthening redistribution of social and economic resources directly and yet the unequal distribution of SDH places many Canadians at a health disadvantage.

The standpoint participants believe that while the frontline policy and program experts may be grounded in HE and SDH concepts, some of their colleagues in high-ranking decision-making positions within the institution are not. One standpoint participant offers insight on her work encounters. The standpoint participant identifies two categories of health promotion programs on SDH that happen within the institution. The first approach to health promotion programs conforms to the dominant North American and is generally vertical, while the second approach to the work on HE/SDH programs is horizontal. Vertical approaches to health promotion are programs and policy architectures that are situated within the preventive and curative focus of

care model, health issues specific and biomedical, while horizontal approaches focus on prevention and are oriented into empowering communities to manage their health problems (Seagar, 2012; Ted, 2009).

The standpoint participant attested to joining the institution when already grounded in the Conceptual Framework for Action on the Social Determinants of Health, a WHO discussion paper authored by Solar Orielle and Irwin Alec (2010). The standpoint participant found that most of the colleagues at her worksites lacked both the awareness and commitment to SDH as was expected. The standpoint participant demonstrated the above findings as follows:

> "The whole of North America is structured in a way that they have a lot of vertical health promotion programs. And I think the work from the other people that I've connected you to is much more horizontal in their approach. And I think that it can sometimes feel limiting. I don't always feel like people understand the language [SDH] that I'm talking, I, you know, like, especially when I came in talking about social determinants of health. I was very rooted in WHO's conceptual framework for action on the SDH by Solar and Irwin (2010). None of this paid attention to such at my work."

Additionally, the standpoint participant revealed that having to experience the gap in knowledge and commitment to HE/SDH in everyday work was only one part of the challenge. The other, and most profound one as such, encountered with the managers. The standpoint participant recounted an incident where a report recommended certain actions on HE/SDH and the manager did not see it as such, the report never moved to the next level. At times the recommendation or the report gets revised accordingly to suppress or undermine the HE/SDH concepts. The standpoint

participant believed that such obstacles to HE/SDH may be prevalent even at the levels above the manager because those decision makers have a different frame of through when conceptualizing health inequities. Most of them have no education or work-related background in these concepts as they may be from a corporate, finance, business, or administrative background. The standpoint participant elucidated as follows:

> "If I make recommendations about a specific issue and use the language such as SDH or HE and my manager does not see it that way, it may never move to the next level or get edited out. I suspect it is the same for those above her such that by the time the report reaches to the top, it is so watered down that the initial meaning is lost in translation."

The above quote demonstrates an experiential work experience that acknowledges the suppressive powers within the institutional hierarchy that is not filled with scientists or experts on HE/SDH concepts. Policymakers narrate how they must always take additional effort to educate those decision makers on the complex nature of HE/SDH work and actions that are needed to move actions on SDH forward, whether in programs or policies. To this, the standpoint participant demonstrated as follows:

> "So that's kind of like not everyone's a scientist or a specialist in that area [HE/SDH], but I think it's just important to understand the institutional part of it and when we have not yet tension. It may be that if this is an important assignment you have to educate people on it as they come in. But ultimately, they decide whether they're experts on the specific issue, or not."

Another standpoint participant demonstrated the corporate nature of PHAC as divided between the President who is a non-technical person in health and the office of the CPHO that is relegated to an advisory role as follows:

> "So, one of the things we've seen of course is the Chief Public Health Officer of Canada is no longer the head of the Public Health Agency of Canada. When it was first set up, the CPHO was the President but after David [Butler-Jones], the President was no longer the Public Health Officer. But it was so initially. Now, the representative of the Public Health Agency of Canada at that meeting would be the president who is not a public health person they're not trained in public health philosophy at all."

The quality of work and the speed of progress in moving HE concepts in public policy depend to a great extent, on decision makers who may be uninformed, lacking either the expertise, the philosophy, or a commitment to HE. However, these individuals occupy very powerful positions in the rungs of the institution, and it takes time to convince them of the practicality of policies made with HE consideration for actions on SDH; most important of these challenges being the nuanced presence of corporate influence from within the institution.

5.9.4 De-Politicization of HE and SDH Work

Within the institution, policymakers are categorized as public servants. As such, there is an institutional tradition that requires public servants to remain apolitical and non-partisan. The political scene at the federal government has been dominated by the Liberals and the Conservative

political parties for decades. Civil servants are expected to embrace policy programs on HE irrespective of the party in power or their personal political views. De-politicization of policy work as an institutional culture has been found to protect the dominant positivist or the pursuit of scientific objectivity. D.E. Smith (1990) acknowledges the role of objectivity in sociology and science generally by stressing that objective knowledge alienates the subject and the subjective experience from a discourse. One standpoint participant demonstrated this dilemma succinctly:

> "I don't know that there's the standard policy or standard operating procedures, but again as a public servant, we are supposed to be apolitically (neutral) people [non-partisan]. So, a lot of what I hear is just letting facts or evidence speak for themselves. I struggle with that a little bit as a qualitative researcher and a former academic because we need to interpret that so that people can understand that or understand the implications of it."

From that quote, the policymaker demonstrates the challenge of being apolitical in an environment where even policy itself may not necessarily be neutral. We saw earlier on that at times, political pressure from interest groups may force the politicians to demand certain policies that may not be supported by evidence. Such a circumstance becomes a disjuncture since politics of the day defines the policies and how policymaking as work is becoming socially organized depending on politics rather than institutional order. After all, political statements embody the interpretation of societal needs and required actions to remediate inequities. Another standpoint participant enumerates the power differences between the policymakers and politicians/bureaucrats like this:

> "You know the institutional thing is that we're not bureaucrats. We're public servants. We are not supposed to have a political affiliation. But, if you understand HE, then you have no choice but to understand that it's a social justice piece…you know, [..] the underlying concept is that HE has kind of notable partisanship. So, the way that I deal with it is by focusing on this piece of programming around how do I take the information. And how do I do this in a non-partisan way."

Invariably, the above quote represents the voices of progress within the institutional stream of policymakers, some oppose the notion of HE policy work being apolitical or ideologically neutral and are conscious of the concept of HE as rooted in social justice. This group objects to the de-politicization of the work on HE because they are conscious that the institution demanding political neutrality in HE/SDH, is subverting the political nature of these concepts. And thus, the policymakers know that social justice work is implicated as inherently political.

Burnham describes de-politicization as a crisis of capitalist development and argues that enforcing such at the workplace is a ploy of enforcing political neutrality as statecraft, a space of contingency that allows the capacity for dominant social groups to privilege a particular idea (Burnham, 2001, 2014). Berry and Lavery treat de-politicization as an institutional practice to be a conjecture intended to create a space within which certain economic strategies and state schemes can be mooted and assailed (Berry & Lavery, 2017). For Jessop, depolarization characterizes the neoliberal political-administrative system, and institutional de-politicization is not accidental at all, as they happen within historical and specific institutions whose role is to stabilize, sustain, and problematize certain dominant ideas (Jessop, 1990; 2014). The policymakers in this institution

understand the pursuit of HE has to do with wresting power and privileges from the rich and powerful to enable the distribution of socio-economic resources needed for health.

In sum, de-politicization is one way to undermine social justice which is the root of HE. A sober conclusion is that de-politicization within this institution is the preferred institutional means of maintaining the biomedical and cultural or behavioral models of explaining health inequalities and inequities.

5.9.5 Departmental Silos Disrupts Progress on HE/SDH Work

The experience of everyday working in silos emerged as the standpoint participant reflected that silos among departments with similar interests in promoting determinants of health through HE considerations are visible. Kaufmann and colleagues acknowledge that public health institutions are silo-driven and lack a unified and consistent identity which amplifies competition among public health specialty areas (Kaufman et al., 2014). Silos are institutional structures, processes, and practices which allow for the severance of different kinds of assets and resources from one another and from departments. MacStravac decried the prevailing dangers in organizational and information silos in stifling interoperability between institutional departments, functions, and even databases (MacStravic, 2007). MacStravic likened institutional silos to "service lines," and argued that at the management level it is nearly impossible to get separate departments and functions to coordinate, likening this onerous task to "herding cats" (p. 108). The standpoint participant, in identifying her work experience as that characterized by silos, had the following to say:

> "One thing you do get is… you get a lot of different departmental experiences. But when you are working in a department, it is very much siloed within your organization. So, you don't always have a lot of connections to other sectors"

The effect of departmental silos is pervasive and affects the work on HE in many ways. One standpoint participant described the immediate impact of such institutional practices to impede intra-local collaborations and coordination. Above all, the standpoint participant revealed that when a person working in a silo is moved to another department, their replacement may never come to know or discover the work already done on HE and SDH. In the words of the standpoint participant, one could detect paradoxes – that of frustration and expectation. This is how the standpoint participant reflected on her work experience:

> "So, if I move to another department, the next person might not know the things that I've been working on related to social determinants. Sadly, that would go with me."

Thus, within the institution, silos not only isolate the policymakers, but also disconnect their works, disrupting a great opportunity for internal and external collaborations as well as knowledge dissemination. Institutional silos offer a challenge for coordinated efforts to gain or share a common understanding of HE and SDH in the policymaking process. If a policymaker does not understand or lacks the commitment to HE considerations, there is hardly a chance to gain influence through collaborations and a broader understanding of the implication of these concepts from others. For an institution structured and managed as a corporate entity, silos within

its department are an anathema to the professed institution-wide embrace of HE as a legitimate goal of health policy.

5.9.6 Frequent Internal Staff Movement Disrupts Progress on HE/SDH

Related to departmental silos is the policymakers' frequent movement to different positions or assignments within the institution. The standpoint participants identified the frequent movement as disruptive to strides being made on HE/SDH and explained their frustrations; holding HE/SDH portfolio for a short period in a highly structured and highly siloed institution means poor communication and accountability for the works that have already been performed. Secondly, there is no guarantee that the replacement has the requisite credentials, commitment, passion, or vision to pursue HE/SDH concepts in public policies and programs as the previous in-charge. As earlier stated, to optimize health outcomes of HE policy work, policymakers acknowledge that they need stability and duration on the assignments and resources. Therefore, the frequent internal movements of policymakers disrupt this process as the adage goes that you take one step forward and then slide ten steps backward. One standpoint participant corroborated her experience as follows:

> "And so, one thing you do guys is you get a lot of different departmental experiences. But when you're working in a department is very much siloed within your organization. So, you don't always have a lot of connections to other sectors."

Another standpoint participant observed that the frequent movement does not happen only at the policymakers' positions or worksites. The frequent change also happens within the senior

level management. These changes could mean many people who lack the commitment to SDH end up taking key decision-making positions with deleterious effects on progressive work on HE/SDH. The standpoint participant captured this work experience as follows:

> "So, if I move, the next person might not know the things that I've been working on related to social determinants. That would go with me, that our senior management also moves around a lot too because that's part of how you get your experience to get promoted."

Frequent internal movements create a barrier to transmitting HE policy work that has started in a silo. The effect of policymaking silos is that those good ideas die in those cubicles once the policymaker is moved from one side of policymaking to another.

5.9.7 HE Pursuit as a Performed Act

The theme which emerged is that the Canadian Federal Government has responded to HE policymaking for actions on SDH very imprecisely. While different actions have been taken to address the growing gap in health inequities among and between different groups in Canada, these actions have been lukewarm and not focused on upstream goals. Thus, the standpoint participants expressed a sense that HE pursuit is merely a performed act with no proper commitment to it within the institution. The standpoint participant stated, and I quote:

> "Although everybody's going to say they agree with HE. I feel that it's about getting the money and the time and the people to deal with those things, which has to happen in almost

every program, anywhere that you work with health and health promotion, HE should be in."

The above quote demonstrates how the standpoint participants perceived the discrepancy in the institutional culture and in the expectations of actors within the same institution to make HE policies. Another standpoint experience reveals how HE works are "super defined" in discourses and narratives within the institution and yet most of the agreements and institutional actions contradict this very principle of pursuing HE. This is how it was stated:

"The institutional texts can tell you what the problem is, they can super define it for you. But all of those moving pieces, like municipal policy, provincial policy, territorial policy, bilateral agreements, constitutional jurisdictions, all those pieces might not be at the forefront. Sometimes they are and sometimes they are not. It is mostly a performed act."

From the above quotations, I concluded that, HE may indeed be the identified goal of public policy response to widespread social inequalities within this institution and across other government departments. However, the policymakers acknowledge that there is more talk about HE policies than there are concrete actions to achieve them.

5.9.8 Experiencing Internal Resistance to HE

I already presented a finding that within the institution, HE is alienated from its social justice motherboard owing to a widely perceived view that social justice is an activist and non-scientific perspective. Rejecting social justice is only one of those many points of institutional

resistances that the policymakers encounter in the pursuit of HE policy. Another bigger challenge is pushing for systemic change as a prerequisite for HE and SDH concepts that may be resisted internally as eliciting a paradigmatic shift. As such, the institution seems stuck on recommending policies whose actions justifiably target the disadvantage for now. Below is a quote from a standpoint participant which captures this dilemma succinctly:

> "I think it goes into systems change. I think that you know, when we talk about HE, we have to stay in the narrow discourse of closing the gap. And, you know, in parallel with targeting the disadvantage. I don't think that anyone is ready for us to move away from targeting the disadvantage."

Another standpoint participant offers the following quote to capture their encounters with internal institutional resistance to moving HE/SDH forward and highlights their experiences with the institutional influence:

> "We wouldn't say it is tension but it's a matter of prioritizing, and what we can actually work on within the public health agency's mandate. One example that I can give you, so, just recently, I was moving something up the chain of command that had to do with social determinants very explicitly and had to deal with a lot of structural policy level of it. And I faced tension from our senior management who didn't necessarily feel that it falls in the social determinants of health as a file."

Internal resistance to advancing HE/SDH concepts was built on questioning the key elements and the meaning of the SDH. This resistance resulted from the lack of a unified definition of SDH or due to the lack of orientation to HE/SDH concepts among the key decision makers and executives within the institutional bureaucratic structure . Further, the need for evidence to meet the demands of accountability compromises the considerations of SDH as a policy priority. The standpoint participant observed that the top management is more interested in easily reportable evidence as opposed to pursuing long-term objectives. This is how the standpoint participant summarized their experience:

> "…from the onset, everyone seems to be on board. They want to make good decisions for social determinants of health and take that to the community. But then in trying to implement something that is fairer you get into this bureaucracy that it becomes so complicated that it takes a long time that you miss the opportunity to do what you are supposed to be trying to do in the first place."

As the quote above demonstrates, internal resistance to the concept of HE is pervasive, and it seems to define the institutional work experiences for policymakers. This is made more complicated by the internal bureaucracy which often frustrates a timely policy and program implementation. Thus, institutional factors such as bureaucracy, set priorities, ambiguity on HE/SDH, lack of orientation among executives, and the demand for quick evidence are found to derail the focus on HE policy for actions on SDH.

In the above section, I presented discoveries that arose from the standpoint of participants' reflection on their subjective experiences derived from doing policymaking work on the HE/SDH

concepts in the various institutional sites. In the next section, I focus on external actors and present discoveries of the influences of corporate/business, political ideologies, civil society, and labour movements on the policymaking process to promote HE/SDH concepts.

5.10 External Influences on Policymaking as Work on HE/SDH Concepts

In the preceding section, I presented findings from the data which highlighted institutional influences on policymakers' work experience. In this section, I identify and describe the role of external actors, namely corporate/business actors, political ideology, civil society organizations, and labour movements in the policymaking work on HE/SDH.

5.10.1 Corporate/Business Influence

The role of the corporate/business or the private sector community in shaping the health of Canadians is acknowledged in several institutional documents. The Strategic Plan for 2016-2019 titled: *Improving Health Outcomes: A Paradigmatic Shift* from the Director-General of the Centre for Chronic Disease Prevention was upfront in its emphasis. It states:

> "Similarly, the very nature of upstream prevention that the centre -- and indeed the federal government – rarely has all required levers at its disposal. As such, we must place a greater emphasis on leveraging resources and expertise from other sectors – public, non-profit, and business." (p.10).

The document goes ahead to justify this multisectoral approach as the lever needed to harness the power of co-creation and co-investment that brings together knowledge, expertise,

research, and resources of all partners (PHAC, 201524). The multisectoral approach was carried forward in the Minister of Health's mandate letter dated December 13, 2019. The PM stated, "It is also your responsibility to substantively engage with Canadians, civil society and stakeholders, including businesses of all sizes, organized labour, the broader public sector, and the not-for-profit and charitable sectors…" (para 10). In the 2019-2020 Departmental Plan the role of corporate/business actors was recognized as follows: "The Chief Public Health Officer works closely with other levels of government, voluntary organization, the private sector and Canadians on public health issues." (p.5)[25].

However, in the 2020-2021 departmental plan, the language describing corporate role was different and clumped under multi-sectoral partnerships while in 2021-22 the Health Minister refers to "protecting communities and their businesses" while retaining a course of action that embraces multi-sectoral partnerships. PHAC as an institution recognized the roles of the private sector in shaping health equity concepts in health policy discourse. Particular roles identified included corporate investments in technological innovations, knowledge development, and translation. However, given such a pivotal role, policymakers should be able to identify the roles of the corporations/business sector. This may not be the case as standpoint participants, depending on their location within the institutional sites, had different experiences with corporate actors – one group recognizing the explicit influence of the corporate/business sector, and another not able to.

24 Public Health Agency of Canada (2015). Improving Health Outcomes: A paradigmatic shift. Centre for Chronic Disease prevention 2016-2019 Strategic Plan. https://www.canada.ca/content/dam/phac-aspc/migration/phac-aspc/cd-mc/assets/pdf/ccdp-strategic-plan-2016-2019-plan-strategique-cpmc-eng.pdf
25 Public Health Agency of Canada (20119). 2019 – 20 Departmental Plan: Public Health Agency of Canada: Protecting and Empowering Canadians to improve their health.

5.10.1.1 Corporate Interest is Explicit (Visible)

One standpoint participant, addressing the question about their interaction with the business/corporate sector recognized the presence and relevance of the corporate/business sector, and had this to say:

> "So, we work closely with an external stakeholder group or come up with more innovative and flexible funding models. And so, I think being able to shape that process along the way, gives me hope and I think it gives validation in the work I do as truly multi-sectoral."

Another standpoint participant higher up in a managerial position was more upfront about work experience with corporations and stated this:

> "A lot of the work that we see around healthy eating/healthy living. The government of Canada has actually partnered with businesses and corporations to do things like national funding, for example, to sponsor big long-term projects, and improve the health of Canadians."

A standpoint participant from a program level authority described work experience with corporation influence as intersecting when social-corporate responsibility ventures are co-planned and had these to say:

> "In my work what I've seen is that corporate interests are considered when I can do a lot of social responsibility ventures. So, some of the work we do within our center involves

public-private partnerships. But, to support community-based interventions and projects that improve health outcomes for Canadians."

In sum, the above quotes demonstrate instances where corporate/business sector influence is explicit such that the policymakers recognize its relevance and work with them to shape health policy. In the section below, I produce narrations where corporate footprint was considered implicit.

5.10.1.2 Corporate/Business Interest as Implicit (Invisible)

Standpoint participants have different experiences with corporate influence mostly due to the social location and social relations that each policymaker has within the institutional power matrix. One standpoint participant observed that at their level, corporate interests were not implicitly expressed, experienced, or made visible. Describing encounters with corporate roles or interests in the abstract, the standpoint participant had this to say:

"You know that goes back to that conversation around thinking globally act locally, got that? That is also the level in which I received corporate interests playing out because they say they make partnerships in their local environment. But I don't see that, like at my level."

Another standpoint participant did not realize or recognize the role of corporate interests or influence in her program, and stated:

> "Okay, so I thought about the fund. And, I would say that in general, I don't know that corporate influence applies to what I'm doing. I don't know of others in the agency who would have the same answer. But I don't see the corporate influence in terms of like commercial determinants of health and things like that."

In the above quotes, the policymakers were not aware that corporations play a role directly or indirectly in shaping health policy equity. Policymakers' experiences with corporate/business sector players varied depending on their location, roles, or assignments.

5.10.2 Corporate/Business Influence is Resisted

Trends emerged during data analysis for some standpoint participants to believe that the government is actively resisting corporate interests and influence in some critical areas of SDH. One example was that the Conservative government actually resisted corporate influence over some aspects of the food industry. The views of this standpoint participant are that it requires political will to resist the powerful forces of the lobbyists. The standpoint participant had this to say:

> "I've maybe witnessed the opposite of corporate power/influence in my work, because, like the Minister of Health refused to meet with the dairy farmers of Canada when they were redoing the Food Guide. And it was specifically for that reason. To avoid that, you know that lobby power, and that the economic voices and economic interests superseding the scientific evidence, and the dairy farmers of Canada are very strong lobby groups. So that was an interesting move, but that is political and not inside of what I do."

The above quote demonstrates policymakers' experience with the corporate/business interests or influences differently based on their assignments and social location within the institutional sites of policymaking activities. The corporate/business sector's influence becomes visible or explicit to a policymaker depending on the experiences a policymaker has and the institutional bureaucratic rank. The higher the policymakers is on the institutional ladder the more exposed to sites of policymaking, where corporate/business influence is explicit. Furthermore, the ability to recognize and resist corporate influence appears to be happening at higher political levels. The last quote above shows an instance where the government resisted corporate pressure from the dairy farmers and food industry manipulating Canada's Food Guide in 2017/18.

5.10.3 The Influence of Labour Movements

The role of labour unions is critical in HE and SDH in a Liberal welfare state like Canada where market income and working conditions are the prime sources of economic security. Studies have shown correlations between better wages and work conditions, HE, favorable societal health outcomes, fairer distribution of socio-economic resources, in societies with high labor density, and the reverse for societies with low labor density (Bosch, 2015; Dollard & Neser, 2013; Eisenberg-Guyot, Mooney, Hagopian, et alt, 2020; Townsend, Schram, Baum et al., 2018). For an institution where HE is integral to public policy goals, one would expect that such an institution would have a working relationship, collaboration, or even a portfolio that addresses the link between income and work conditions.

When asked about the role of and relations and experience with labour unions and unionization all the standpoint participants were surprised. There were sudden disruptions in their

interactions and changes in their intonation, suggesting they were being caught off guard by the inquiry. One of the standpoint participants demonstrated this point like this:

Interviewer: What is your experience with labour movements, do you collaborate with these folks in your work?

Standpoint participant: Not much. We are pretty isolated like the way that we work because grant-making is the key. We're a very top-down organization. We're trying to change that a little bit we're trying to look horizontally but not much.

Interviewer: Does everyone who considers themselves policymakers feel the same, no working relations with labour unions or even a consideration?

Standpoint Participant: That said, it would be a different conversation if you were talking to our funded projects because we do want them to work with their partners and that can include labour unions. I can't think of any off the top of my head, but it does often involve talking to like the political arm and it does often involve navigating that political conversation and ideologies. But we're really removed from that and that's for the purposes that I don't know.

This revelation is clear that there may be an inter-governmental or inter-departmental collaboration happening. However, these processes exclude the people in the institution who should be participating in these conversations. This finding lends credence to the nature of departmental silos. It also offers insight into the challenges of addressing HE and SDH when the approach narrows and excludes key players such as labour unions. In the meantime, evidence

demonstrates that corporate/business sector players are incorporated in policy planning from a very high political authority as partners in shaping health policy.

5.10.4 The Influence of Civil Society Organizations

Mulvale et al. (2013) placed a rather unique relevance to engaging civil society organizations (CSOs) in deliberative dialogue. Mulvale and colleagues reiterated that civil society is increasingly being used to address 'wicked problems' in policy-making, and recognized the role of civic engagement in the formation of Canada's first national mental health initiative (Mulvale, Chodos, Bartram, et al., 2014). The role of civil society organizations in promoting HE in public policy is well documented all over the world. CSOs are accredited for mediating and moderating the role of various actors in the policy-making process. Moreover, stronger CSOs gain the immediate attention of bureaucrats, policymakers, and politicians and a strong relationship between government and CSO favours amicable policy changes (Babis, 2014; Lim, Lee, Suh, et al., 2014; Smith, Buse, & Gordon, 2016). Additionally, civil society is a complex concept that requires attention to nail it down. The World Health Organization (2017)[26] observes that civil society represents the social sphere separate from both the state and the market. Thus, civil society organizations (CSOs) represent the non-state, not-for-profit, voluntary organizations formed by people in that social sphere. In other words, engagement with civil society is often seen as engaging the citizens in their everyday life.

The lack of engagement with CSO also could mean developing policies that are exclusive of the everyday experiences of Canadians in their communities where social inequalities play out.

26 World Health Organization: Civil Society and Health. Corpenhagen, Denmark: European Observatory on health systems and policies.

Thus, it is important to understand how the pursuit for HE as a goal of health policy necessitated an inquiry into institutional practices and the everyday works that the standpoint participants performed. When asked about the standpoint's daily encounters with CSO, it emerged that there was little or no direct contact or interactions with civil society organizations at the mid-level or managerial levels. The standpoint participants expected that the frontline federal policy, program, or initiatives implementers would be more intimate with civil society organizations. One standpoint participant stated their work experience with CSO as follows:

> "I do not interact with CSOs. Not much. We are pretty isolated like the way that we work because grant-making is key. We're a very top-down organization. We're trying to change that a little bit we're trying to look horizontally but not much."

When prodded further to reflect on the role of CSOs in the work that they do daily, through coordination and inter-departmental collaborations, the standpoint participant responded:

> "It would be very hard to do what we do without CSO, it's interesting because I used to work for [an International Organization], and I would tell people working in my position to work with these people - CSOs. So, it's weird to me that we don't, but we don't."

While the policymakers and mid-level managers do not work or socialize with civil society organizations, they appreciate the role of CSO in shaping health policy. Some of them have worked long enough in the institution to have recollections of how CSOs have influenced policies, programs, and initiatives. This is how a standpoint participant summarised their experience:

> "But I do see external influence from our advocacy groups. So, we tend to be fairly interested in learning about the social media content of Policy Think Tanks or CMAJ or CNA emerging issues. Yeah, we are interested in what the advocacy groups for professional associations are saying and what they might be saying we should do about social determinants of health."

The policymakers may show a legitimate interest in what professional associations are saying about emerging gaps in health outcomes and their recommendations for actions. This pressure would bear more fruit when targeted at decision makers such as managers, directors, and so forth. However, it emerged that the interacting impact of CSO activism is usually targeted at politicians. One standpoint participant recognized that CSOs usually interact at a high political level. As such, their pressure for action on HE and SDH is felt within the political class and not the technical or bureaucrats. This is how they summarized their experience:

> "So civil society does have an impact. I think it would have more of an impact if it were actually sent to our decision makers or their staff for one example. You know, I might meet with someone from an organization, and we have a good conversation, but I can't really do anything, because, you know, we don't have money, but then if they go to the Minister and the request trickles down to our department in the Minister wants to support something then all of a sudden something that happened right."

The standpoint participants gave an example of the Mental Health for Black Canadians as an outcome of direct pressure from CSO groups and summarised the experience as follows:

> "As you know, the mental health of Black Canadians program came from our federal government's meeting with members of the Black community, who identified that they have community mental health needs. And so, the government announced funding. And so yeah, I would say advocates certainly do have influence."

The standpoint participant was quick to appreciate the role that civil society organizations play in shaping health policy and had the following to say:

> "Overall, I think the external influences, whether they're advocacy groups, researchers have a huge impact in, in the work we do. I think, given a government work or working for and with the government, it is a political contact. So, I think having those voices brought to the table or the momentum of certain issues certain causes change. This is one way to get certain items on the political agenda."

In sum, the role of CSO in shaping health policy discourses is well recognized at the PHAC institutional sites. Policymakers demonstrated interactions with CSO depending on each one's portfolio and ranking in the organization. An example of a program funding that resulted from a need identified by the Black community for mental health serves to justify how CSO can exert positive pressure at the political levels to get results.

5.10.5 The Influence of Political Ideology

Canada is a pluralist society with a multi-party system of governance. The primary parties that have influenced politics in Ottawa are the Conservatives, Liberals, Bloc Quebecois, and New Democratic Party. Each party has its distinctive ideological characters with a profound influence over the distribution of social and economic resources. Despite their differences in ideology, scholars have identified Canada, alongside its contemporaries such as the USA, and the UK as belonging to a Liberal welfare state (Arts & Gelissen, 2002; Esping-Andersen, 1990, 1999; Raphael, 2013; Saint-Arnaud & Bernard, 2003). This means that their programs and outlook on social and economic inequities are more of the same. In the last century, the two most dominant parties that have consolidated their power and influence over Canada have been the Conservative and Liberal parties of Canada. Thus, much of the influence that is being analyzed here pertains to influences from these two political parties. Therefore, it was important to inquire from the standpoint participants how changes in governments or political ideology affect their everyday work on HE policies.

5.14.5.1 Polarization Effects of Populist Regime Change

It emerged that with the two political parties usually changing the mantle of power between them, the country gets polarised on many fronts with innovative ideas likely to arise from provinces and territories. These policies affect population health and make the work on achieving HE as a policy goal for redistribution of social and economic resources very complex. The standpoint participants acknowledge that when Canada becomes politically polarised and that such polarization is not good for the work on HE/SDH. Under such a polarising political environment,

a change in government usually leads to a major shift in priority work on HE/SDH. This is how she captured the essence of the experience:

> "I'm just thinking like, as a country, in the direction that we're going where we seem to be polarizing, I think we might expect a lot to come in the middle of those two extremes in the future, which maintain the status quo and doesn't necessarily look for radical change or, you know, radical spending on really huge population intervention, either in the health sector or outside of it. I could be wrong. But I think, I think things just get diluted, so the intention is to act on social determinants to redistribute resources, so people have more equal opportunities. But it's very hard, and it's very complicated, even when you have well-meaning people and programs behind them."

In the above quotation, extremism is seen as disruptive to advancing HE/SDH. The standpoint participant demonstrated pessimism for the future of HE/SDH concepts due to institutional sensitivity to changes in political ideology in government. Although the standpoint participants may wish for a third-party intervener, it appears that Canadians themselves believe in the programs that the two dominant political parties of Conservatives and Liberal offer. There is a silent third party, the NDP recognized in the interview. However, the standpoint participants acknowledged that it is not the place of civil servants to suggest which party would provide the most favorable conditions for pursuing HE. One thing that stood out for me in this testimony is the recurrent theme that political changes disrupt the pursuit of HE in Canada. Thus, standpoint participants were ambivalent as to which political direction and circumstances would guarantee continuity of Health equity promotion in health policy work for actions on SDH.

5.10.5.2 Conservative Ideology is Anti-HE

It was a common experience for the standpoint participants to notice that changes in government from the Conservative to the Liberal and vice versa, had a profound instant impact on promoting HE/SDH. The standpoint participants noted that the Conservative Party, once in power, rejected nearly everything that the previous Liberal party pursued. One standpoint participated summarized their experience:

> "I had done my master's project focused on adolescent sexual health, I came in working in the area of HIV and STI prevention, and shortly after that, the Conservative government came to power in an election. And there was, I noticed a drastic shift in terms of what we were able to do and what we could not do."

Pressed further to explain how unfulfilling and disempowering the whole experience was in her everyday work and collaborations, the standpoint participant reflected:

> "Even if you're aware generally of the kind of different political platforms, obviously at that time under the Conservative government there was no support for activities such as harm reduction. But that is the nature of the work we do in sexual health. It is that we work towards fulfilling the mandate of the government in power, so it is very disruptive and disempowering."

The standpoint participant understood here that managing change in such a short time was difficult. However, she advocated for a sort of independent public health where changes in political ideology should not disrupt established departmental plans or work already affecting communities. This is what was said:

> "I mean, obviously in public health, there's a lot of really important work to do. It's kind of essential. Public health plays an essential role, and it shouldn't be minimized or disrupted regardless of whoever's in power politically."

Conservation politics have a profound implication in our effort to see public health as either a progressive or reactionary institution. Based on the above themes, public health seems to be used as a tool to achieve a goal. As such, each political party in power can sharpen its tool as they wish. These shifts lead to effects upon real Canadians who fall by the wayside as changes in governance may disrupt the legitimate opportunity for reducing the gap in achieving HE as a health policy goal.

In the above section, I reported on discoveries that described the policymakers' work experiences with external actors in the corporate/business sector, CSO, political ideologies, and labour movements. I demonstrated that encounters with each of the influences and influencers depend largely on the policymaker's portfolio and rank in the organization. Certain files attract certain actors more than others. The higher one is situated along the institutional hierarchy, the more likely they experience corporate/business and CSO pressures. Changes in the political environment have always affected HE/SDH negatively, while the Conservative regimes undermine HE/SDH policy work.

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5.11 Levers of Change: Hope and Optimism for Systematic Change

The standpoint participants in my study were all connected by an invisible thread of optimism, believing that somehow by hanging on to the institution, circumstances favorable for a paradigmatic shift would come around. Bissaillon (2012) observes that uncovering the ruling relations within an organization permits us to explicate social relations of struggles and that offers the opportunity to identify specific places of change. Devault and McCoy (2004) refer to this unfettered journey as uncovering the levers or targets of change. Thus, in interacting with the policymakers, there was zeal and optimism for some opportunities to moving forward despite all the problematics, and these findings are captured under the following themes:

5.11.1 Seeking a System's Change Approach

The standpoint participants alluded to their efforts at ensuring that inter-departmental collaborations happen for a holistic approach to HE and SDH. Using a holistic approach or across departmentally-funded programs are not a new idea within the institution, rather, they are rare. One standpoint participant reflected on successes in the past when funded programs were designed with such a holistic approach and were very successful:

> "What we focused on in the past is to create an environment that allows that programming to happen, kind of in a holistic way. And what we've seen from the past funds, is that they were the most successful projects in the areas of HE and health policy. Healthy public

policy rather is those that looked at things from a system's change point of view, and system changes part of what we fund."

For this standpoint participant, a system's change reveals the lack of commitment to legitimately pursue HE goals in public policy within the institution. A system's change, thus, involves mobilizing the whole to act together within the system to achieve the desired change. To elucidate this perception, one standpoint participant stated as follows:

"A system change is a loaded term. Change at the system level is like the compilation of the different actors and the social environment in which the actors are working it's their network, it's there. It's the way the system and the cultural aspect of the system kind of work together. So, systems change can be things that can be as little as a policy that creates training at the organizational level across the country for law enforcement officers in the way that they deal with youth. And then equity piece says a different training that supports the way that they deal with youths from marginalized communities."

The standpoint participant here demonstrates an understanding of the untapped potential for her institution to redirect its powers constructively to the pursuit of HE/SDH. The standpoint participant lays down examples of how this holistic change could occur as changing conversations or changing institutional culture. This change could start small and incremental and could grow with support from political actors. She seems to be alluding to the very social organization and the ruling relations that have, over and over again, trumped upon legitimate attempts at achieving HE for Canadians across the country. This is how it was stated:

> "And it can be as big as changing the conversation and changing the whole culture. So, the conversation around food banks was big in the 90s in the early 80s in Ontario, and there's been a lot of work around systemic change. It was intentional it was out of one of our funded projects they were funded by many different pieces so ours was just a small piece of that. But they were able to have the conversation shift into Community Food center, and food security, you know. We haven't seen the full fruition of that in terms of the political discourse, but certainly, in the programming landscape we've seen that shift happening, it's slow it takes time. And it's hard to measure which is another piece that institutionally we don't like."

When asked whether this kind of change-eliciting conversation is happening both horizontally and vertically within the institution, the standpoint participant was quick to state that there is intolerance within the institution for certain conversations. Given the example of that scholars could easily discuss redistribution of power and socio-economic resources as the premise of legitimate work on HE. This kind of conversation does not happen within the bureaucrats in the institution. This is how it was summarized:

> "I mean, in a bureaucratic setting, we've never talked about power redistribution in line with HE and SDH. That is not possible here. But, yes, exactly in an academic setting. That is the translation to academia for what system changes."

In the above quote, the standpoint participants explicated on the extent they conceptualize a system's change to involve a discussion around the redistribution of power, wealth, and prestige. Most of the bureaucrats enjoy these dimensions of social stratification and therefore do not see the urge or urgency for change. Haller (1970) summarized the challenges that a system change approach may offer. Haller recognizes that people in certain social positions resist the system's change because of their privileged position in power through which they exert control over others or institutions and wealth. Thus, when change occurs in their prestige or "the social definitions of controlling ways in which they evaluate each other" (Haller, 1970, p. 473), it alters some of the most profound social relations among such groups (Avelino & Rotmans, 2009; Haller, 1970).

Borrowing from Durkheim's theorizing of "anomie"(Bernburg, 2002; Durkheim, [1897]1951), Hailer argues that structural change of this nature destabilizes and disrupts both the interpersonal and intergroup behaviors and establishes norms making them act out of order. Haller thus concludes that any changes in the structure of a status system involving redistribution of power, changes in the level of wealth, or a change in prestige, produces anomie (Haller, 1970). The struggle for a structural/system's change offers a glimmer of hope, but for now, it appears to be a protracted struggle within institutional sites of policymaking.

5.11.2 Envisioning Closing the Gap

Complimentary to advocating for and investing in system's change, the standpoint participants have reimagined adopting closing the gap through a health system change. This health system change would replace the current dominant process, targeting the disadvantage which is narrow in its approach in addressing health inequities in society. The standpoint participant uses

studies of the European welfare economies both the Conservative and the Social Democratic nations, as good examples of where closing the gap concept have taken root:

> "So, in the Conservative countries of the European welfare state and the Nordic countries, they focus mainly on closing the gap and transformational policies. So, I think for us in our context, the future is really in that piece of adding a part to the conversation so that we're not just talking about targeting a disadvantage. We're also talking about closing the gap. And that means this can change."

With the quote above, the standpoint participant invites optional approaches to HE work, but rather in a resigned way because it is understood that the institution and the policy decision makers in this country are still far off that mark. The participant clarifies what she meant by closing the gap while offering to articulate the challenge of this option as not meeting the scientific demand of the dominant policymaking process, stating:

> "So, when I say closing the gap that's also not a scientific language, the terms that I have to use become systems change. HE and systems change. That's how I say closing the gap to people who don't know what I'm talking about."

In speaking with the standpoint participants to gain an understanding of their expectations, given their knowledge and clarity of idea as to which path to pursue, when asked to evaluate the status of HE regarding its popularity as a health policy goal, the response was:

> "I do not see an equitable society. And I wish I had a different answer. And I don't know if you are familiar with the work of Hillary Graham [2004 -Tackling inequalities and help in England.](Graham, 2004). She's an academic from the UK but classically argues both differences of policy language between things like for mediating health gap or leveling the playing field and those sorts of things."

Graham (2004) made a compelling case to differentiate various political strategies that could be used effectively to respond to growing social inequalities in England and the developed industrial countries. Graham rejects the singular focus on the population health approach and emphasizes that strategies that are aimed at the poorest groups often fail to change the social gradient (Graham, 2004). According to Graham, an inclusive approach – narrowing the gap – should focus on reducing the social gradient through bold structural and political measures across many facets of society (Graham, 2004; Strand & Fosse, 2011).

5.11.3 Re-Constituting Institutional Clarity over HE/SDH Concepts

The standpoint participants have encountered ambiguity in the way HE/SDH are communicated textually and discursively in their daily work. However, ambiguities in policymaking are not a novelty. There is a well-established place of ambiguity in policymaking. Zahariadis (2003) makes a compelling case for ambiguity in policymaking arguing that society generally is incomprehensible because voters and politicians do not know what they want – voters make choices they shouldn't, and politicians make promises they lack commitment, time, resources, energy, or intention to fulfill. The government is always asked to solve problems they

do not understand well with instruments they have not tested; policymakers are plugged in there and try to find a delicate balance that gives tenancy to ambiguities (Zahariadis, 2003).

However, from Whitehead's (2007) typology of actions to tackle social inequalities in health, we learned that implicit or explicit statements of intentions do predict designs and possible outcomes of policy programs. Work on SDH and HE have either been targeted at individuals in order to strengthen them, as well as the communities, and improve living and working conditions and essential services while promoting healthy macro-policies (Strand & Fosse, 2011; Whitehead, 2007b). Policymakers have had challenges requiring that they respond in fast, multi-complex policy situations when evidence and clarity around policy goal remains ambiguously framed (Cairney et al., 2016). Thus, the lack of institutional or all-of-government unified understanding of both the concepts and concrete policy actions needed to achieve HE in public policy is interpreted as part of the conceptual practices of power prevalent within the institution.

The standpoint participant recognized the above through their daily work experience and argued that it is of utmost importance to articulate HE/SDH concepts, goals, actions, and resources needed from the beginning of the policy process to the end of policy implementation:

> "I think that's where we talked about closing the gap in the processes. I think that it is a good level of work in the processes in the trenches of policy implementation that we can do those things to promote HE/SDH and that means the people doing it, the human resources needed to understand what they're doing intricately, in a critically thought kind of way."

The standpoint participant is reflecting on everyday work experience and feels the sense of disconnect and alienation from the social processes of policymaking. The ambiguity or lack of clarity creates frustration. Below are reflections that reveal that within the institution, many decision makers indeed understand the language and the actions needed to move HE/SDH forward. Thus, clarification and harmonization of the textual and the discursive understandings of the concepts must happen before policymakers and their partners begin a partnership. And I quote:

> "I think as I mentioned because there are varying degrees of understanding of kind of the basic social determinants of health language and HE. I think it's always important when we meet with different stakeholders when we're faced with different paths that we, first of all, clarify questions in what context, are we using these terms in this language to make sure that there's a common understanding."

The ambiguous nature of communicating HE and SDH within the institution and as corroborated with its various partners demonstrate a lack of concrete agenda to take action. This may partly explain the conspicuousness of these concepts in health policies and policy programs beyond the narrow focus.

5.11.4 Re-Engaging the Communities: The Declining Community Consultation

One of the challenges that policymakers demonstrated is the experience of being disconnected from the communities in need. I found themes confirming a decline in community consultations. Standpoint participants recognized that community consultation is poorly conducted for purposes of validating an already existing funding scheme. As such, standpoint participants

have grappled with the decline in community engagement because it excludes community voices from HE policy, programs, and innovations designs. The loss of community participation undermines the most important community voice needed in health policy and the pursuit of it. Standpoint participants confront a diabolical situation where community consultation happens to a targeted population and excludes key SDH issues such as housing, food security, social exclusion, and so forth. Policymakers, basically, come with a pre-determined top-down and therefore, such consultations are driven by instant political or economic agenda. One standpoint participated stated it this way:

> "I mean we're always trying to stay on top of the current landscape in terms of who are the different stakeholders, what are the different issues... but that's when we kind of, at the outset of developing, in our community-based funding program we did community consultations across Canada, trying to talk to the different stakeholders from diverse backgrounds representing different issues and populations within the Black Canadian community. And, off the top of my head, I don't know like who or, you know, what group or housing but that's, that's an opportunity where we would have tried to reach out and cover off kind of the different determinants of health, as they relate to mental health and Black Canadians."

The standpoint participants recognize that engaging stakeholders in all the issues of SDH from the onset would generate better planning and better policy programming. One of the standpoint participant's weighing in on declining community engagement, stated as follows:

> "And so, I think engaging those stakeholders at the outset, and then throughout the process to check in to see what those issues are, what are the gaps, how could we better partner with them matters, and we miss it. So, it's definitely something that we're familiar with and part of our work in building, you know, a strong evidence-based program."

In sum, public health leaders are allowing community consultation to slip off their hands and consider health policy tailored to achieve health equity. Without the community voice, the socio-economic inequities that people experience every day never get addressed. Instead, we get a narrow approach to SDH issues by design rather than by an authentic mistake. Herein lies the problematic that confronts the policymakers in their everyday work as they are confronted and challenged by institutional conceptions of power on HE/SDH.

5.11.5 Reasserting the HE and SDH in Institution Language

Stakeholders' involvement in health policy is an important lever for health policy change. This concept is rooted in the 1978 alma Ata Declaration which sets an ambitious goal for Primary Health Care (PHC) as the vehicle of achieving universal health care in the world by the year 2000 (Adeleye & Ofili, 2010; Kriegner et al., 2021). Multisectoral collaborations have documented benefits, such as early engagement of non-health sector, harmonization of methods, approaches, theories and leveraging resources, drawing interests of non-health partners in evaluating health impacts of the partnerships, and may reduce tensions between health and non-health actors such as corporations/business (Kriegner et al., 2021).

The standpoint participants recognized that engaging stakeholders in SDH and HE issues from the onset would generate better planning, better policy programming, and consequently,

better outcomes. To achieve this goal, public health and health policymakers have to design a language that resonates across non-health stakeholders. Acknowledging that multi-sectoral partnership is an important dimension of a system's change when mobilized from the onset of the partnership, one standpoint participant had these to say:

> "Taking a look at how the comments of approach to systems change may mean one thing for one population and community: and something completely different for another. This is the challenge we have, as we continue to make those linkages and try and bridge the gap across government and the different sectors. It's how do we kind of tailor our language to make it resonate in non-health sectors."

In the everyday work of the policymakers, the role of multi-sectoral collaboration offers the opportunity to shape that language that can resonate across the non-health sectors. The standpoint participant's frustration with the everyday adherence to the institutional language was explained as follows:

> "I think, more commonly we use language and terms like addressing the root causes. I think recognizing that terms like HE or SDH are very grounded in a health context and may not always resonate with non-stakeholders."

Reflecting on how health policy work on HE is socially organized within public health and within PHAC as an institution, the standpoint participant demonstrated frustration with

departmental and inter-organizational silos and wished to find solutions to end these silos if it were possible.

In the above section, I presented discoveries from the standpoint of policymakers as to areas they believe to represent a more optimistic future for policy work on HE/SDH. To better move HE/SDH forward, policymakers strive to target a system's change that focuses on closing the gap as opposed to targeting a population. They recommend that HE/SDH concepts have to be reasserted in institutional discourses – texts and discursive – ending ambiguities and seeking clarity whenever HE/SDH recommendations are made. This should be at the top of policymakers' agenda; in order for the community and civic engagements to raise the profile of HE/SDH politically.

5.12 Summary of the Chapter

This chapter provided an institutional analysis of PHAC as one of the sites for health policymaking in Canada. The analysis was an attempt to unveil policymaking as work conducted by persons designated as policymakers whose works span multiple sites. The data revealed that there is a consensus within PHAC as an institution that HE is an urgent goal of health policy for mitigating increasing socio-economic inequalities. The PHAC as an institution is one of the federal government's strategic organizations that constitute the health portfolio designed for maintaining and improving the health of Canadians (Government of Canada, 2017). The purpose of PHAC is to promote public health and to report every year on the state of public health in Canada to the Minister of Health. The Minister of Health then brings the state of the health report to the Parliament of Canada for review. The organization derives its mandate from the PHAC Act, 2006 enacted on the heels of SARS to be a watchdog for health security in Canada. By health security,

it is meant an organized effort to respond to external threats to the health of Canadians – such as pandemics or bioterrorism (Peer, 2019).

This section presented an analysis of discursive and active texts used within the institution to socially organize policymaking as an everyday actuality of policymakers. We found that activities that constitute policymaking are numerous and spread in multiple worksites; occurring simultaneously or sequentially between and across these sites. Textually, we mapped HE and SDH concepts in the Minister's mandate letter, the PHAC Act, 2006, and the Annual Departmental Plan. Our goal was to map these texts out to identify at what levels are HE and SDH concepts visible, actively engaged with, mediated, resisted, or insubordinate. These texts constitute the ruling relations as they directly organize policymaking work when activated at sites of policymaking work. The study contends that HE and SDH concepts are visible to an extent in the Minister's mandate letter, although not explicit, allowing possibilities for multiple interpretations by the Minister of Health. Mapping HE/SDH concepts in PHAC Act, 2006 demonstrated that these concepts were not the focus of the Act; rather, an emphasis on "evidence derived from scientific processes" was the focus of the report of the Chief Public Health Officer.

The standpoint participants or policymakers in the organization are hooked onto their worksites through the Departmental Plan. This is the annual document that the Minister of Health releases to guide health policy, programs, and innovation priorities. The Annual Departmental Plans are the fine print of the ideological approaches to health for the party in power. It also reveals the Minister's interpretation of the letter of mandate. The policymakers are then hooked on programs that are funded based on political commitment, political pressures, and evidence of social inequalities in Canada.

By analyzing five previous and the current Annual Departmental Plan, the study demonstrated that HE and SDH concepts are vaguely embedded or incorporated, described, or talked about. The obscurity and ambiguity in the language and the nature of programs intended to promote HE/SDH made it difficult for policymakers to build consensus on what it is that HE or SDH are, and how to achieve their policy goals.

In analyzing the institutional structure, the study found that the policymakers at the departmental levels were highly educated, exposed, experienced, and familiar with the concepts of HE/SDH. However, the organizational leaders who make the most potent decisions usually do not have a background or solid understanding of HE/SDH such that whenever these issues arise, a lot of explanations are required. Policymakers' daily experience of confronting such a disjuncture was identified as commonplace within the institution.

Within the institution, there are multiple and competing conceptions of HE/SDH. While both concepts are embraced, they are also resisted, subordinated, and often obscured from mainstream discourses because they are hard to measure, and that they are sporadic and often obscured in discussions; at times even edited out of main texts as hard to understand. HE is ripped from its social justice roots and touted as an activist and not a scientific concept. Policymakers acknowledge that work on HE/SDH takes time and needs resources for periods longer than a decade for it to materialize. Furthermore, HE/SDH concepts often face resistance when other health priorities emerge or when the political environment changes.

Canada has recognized the negative effects of social inequalities on Canadians in the same way as it was articulated by the 2008 World Health Organization's Commission on Social Determinants of Health. These inequities are echoed in the subsequent 2008 annual report of Chief Public Health Officer, Dr. David Butler-Jones's opening remarks, and re-echoed in the 2009

Standing Senate Committee on Social Affairs, Science and Technology's Final Senate Subcommittee on Population Health – all of which affirmed that health is largely determined by factors outside the health care system and therefore actions were expected to close the gap by focusing on redistribution of social and economic resources where Canadians do not have equal access to. This clarion call to action was an ethical imperative that Canada seems not ready to commit to in practice although they have popularized it in theory.

This study confirms that political context in which health policy for action on SDH in Canada is reliant on the politics of the day., This confirms observation by scholars that irrespective of which government is in power, concerns of social inequities are not being addressed adequately through public policy (Raphael, 2015; Raphael, Brassolotto & Baldeo, 2014). Raphael, Brassolotto and Baldeo found that not only does the political context matters, even the specific ideological commitments held by Medical Officers of Health and staff within an institution actually determines the extent of work for carrying out SDH-related activities. At least, this study agrees that social and health inequities are not being addressed to the level articulated and expected by the WHO Commission on Social Determinants of Health.

This study demonstrates that progressive strives towards enacting equity-based health policy are being resisted through conceptual practices of power with public institutions like PHAC. These conceptual institutional practices of power are characterized by narrow approaches to HE and SDH that focus on the individuals. The narrow approach views health as a product of individual attitude, behaviour or lifestyle, and lack of education or cultural issues (Shah, 2003; Shah, 2003). Aggleton (1990) attributes these institutional practices as socio-positivists – relying more on observable and measurable phenomena – and therefore a great proclivity for cause-effect relationships among variables. In capturing the essence of my findings, Aggleton's description of

social positivist practices, with its defining characteristics such as cultural analysis of poor health and individualistic explanations of health, affirms the narrow approaches on the promotion of HE and SDH in this institution.

It follows that at the high political levels, the Health Minister's mandate letter provides grounds for the promotion of HE and SDH, albeit imprecisely in most areas. However, in the same letter, the interpreting of what constitutes work on HE is subjective such that the Health Minister and those below her in the institutional hierarchy can framework on health equity as they wish or without a sense of priority. Furthermore, the PHAC's emphasis on "scientific evidence" as the basis of analysis of the state of health of Canadians reiterates positivism as a preferred conceptual institutional practice of health policymaking and thinking about HE policies. The real challenge is that those who demand scientific evidence lack the competence and interest to use it in decision-making. Thus far, policymakers have hopes that one day Canada may embrace a system's change approach for closing the generation gap of health inequities that steps away from the traditional narrow focus on HE and SDH considerations.

This chapter concluded that although there are so many opportunities provided at the federal level to advance HE/SDH concepts, the corporate and bureaucratic structure, and the characteristics of the people in positions of power subvert legitimate work to achieve health equity-focused policies for action on SDH. Most importantly, practices that take narrow approaches to population health may explain why HE/SDH concepts are not filtering in public policies in Canada. On the other hand, policymaking practices that tend to take broader approaches to resolve health inequities such as narrowing the gap, gravitate towards promote the lacking HE and SDH concepts and offer better opportunities to reduce inequities in the health of Canadians. In an ideal setting, progressive and broad approaches should focus on redistributing social and economic resources

for health to reduce social inequities. Additionally, such policymaking practices should be practical to address housing deficits, work and job security, incomes and income guarantees, secured early positive childhood development, social inclusion and social safety networks, food security, education and literacy, income and social status, Indigenous status, gender, sexuality, race, and disability. The next chapter presents discoveries from policymaking work at the provincial level of government from texts and policymakers' everyday work experiences, where HE/SDH is visible or obscured, concealed, resisted, or subordinated.

Chapter 6: HE Policy and SDH at the Provincial Level

6.1 Introduction

In Chapter 5, I provided discoveries of the institutional characteristic of PHAC as a health policymaking site of choice. I presented discoveries from textual analysis and illuminated the ruling relations as well as the social organization of policymaking as work. I then presented how SHE/SDH concepts are conceptualized, discussed, made visible through various institutional processes and the process interchange. I provided insights into the bureaucratic architecture of the institution and its implications for promoting equity-focused health policy for actions on SDH. The section discussed the everyday work experiences of the policymakers, their conceptualization of HE/SDH concepts, and their everyday experiences with the institutional character and influence over HE/SDH concepts. Subsequently, the section discussed how the institutional conceptual practices promote the conceptualization of HE/SDH in health policy. In conducting my analysis, I keenly followed D.E. Smith's (1987) suggestion that for IE study, attempting to study or map out every institution to its totality, is a time-consuming feat. Therefore, the focus in IE research is to explore corners or strands within a specific institutional setting in ways that make their points of connections with other sites and other connections visible (McVault & McCoy, 2006).

As a caveat, in this section, the focus of my study was not leveled on a particular institution such as PHAC or Public Health Ontario. I studied the standpoint participants whose policymaking as work experience interfaced with the legislature as an institution of policymaking. Furthermore, I could not delve into a deep provincial institutional analysis as I did in Chapter 5 for two reasons:

1. the Canada Health Act assigns the mandate of delivering healthcare and public health to provinces which have led to most policymaking decisions happening at the provincial legislature where the Provincial Health Promotion and Protection Acts arises. Actions on health equity occur

in a few provincial institutional sites, however, most of the organizing influence of provincial health policy activities happen at the municipal level and transmitted through the Provincial Public Health Standards to Public Health Units. This is especially true in Ontario whose municipal level action on HE/SDH concepts was the focus of my study.

2. The interview data from three provinces provide insights into what policymakers do at or around provincial legislature, and how they do their work, including institutional promoting considerations of HE/SDH at the provincial government level at the Parliament. This means that I was unable to interview standpoint participants in a specific site of policymaking outside the legislature, such as Public Health Ontario and Ontario Ministry of Health or such bodies in Saskatchewan and British Columbia.

In order to manage the data (including texts) and present a faithful account of my discoveries, I dedicated time to analyzing provincial-level documents/texts that organize the delivery of public health at the municipal level of government. In Ontario, the focus of my study was actions on HE at public health units as informants were not available at the Provincial level for reasons possibly related to the political environment. The proceeding section discusses discoveries of policymakers' conceptualization and actions on health equity and social determinants of health at the level of provincial parliaments. Thereafter, discussions tappers off to happenings in Ontario.

6.2 The Provincial Government Level as Site for Policymaking

Canada is a federation of ten provinces and three territories spread across half a continent with five different time zones. The population distribution is best described as irregular across the

provinces and territories with Ontario having the largest population. According to Statistics Canada[27](2021) for quarterly population estimate in second quarter of 2021, Ontario recorded a population of 14,789,778, followed by Quebec with 8,585,523, British Columbia with 5,174,724, Alberta, 4,444,277, Manitoba registered 1,382,904 and Saskatchewan with 1,179,906. Prince Edward Island had the lowest population of about 160,000 people. The viewpoints in this study were collected through interviews with policymakers from Ontario, Saskatchewan, and British Colombia – representing the largest English-speaking provinces in Canada.

The standpoint participants included legislators, political party leaders in the opposition, Civil Society Organization (CSO) executives and program managers, former government bureaucrats who are now external consultants, former policy advisors, and directors of health agencies (Research, Think Tanks). All the participants had multi-disciplinary educational backgrounds in health and did demonstrate a good command of HE and SDH knowledge accumulated from work experiences for over decades. Many of them had senior roles in a variety of public health portfolios over many years.

The credentials of participants were impressive. One standpoint participant demonstrated her knowledge, expertise, and authority based on her previous work at a provincial ministerial level as follows:

> "I worked at a ministerial level. I started at the local (municipal) level. I basically avoided working at the federal level. I never had any intent to do so. I actually never thought I'd work at a provincial level, but I did end up doing that for a few years."

[27] Statistics Canada(2021). Table 17-10-0009-01 Population estimates, quarterly
DOI: https://doi.org/10.25318/1710000901-eng

Moreover, the work experiences of some of the standpoint participants panned over four decades as this one enumerated:

> "And so that was the beginning of 40 plus years where I focused on addressing inequities in health."

In sum, the standpoint participants that I spoke with had a great wealth of hands-on experience, knowledge, and authority on the subject of our discussion. One of them was a retired former professor, another one a medical doctor and elected politician, a former deputy minister, and a provincial medical officer of health. One of the informants worked in public and private practices at various provincial levels.

6.3 Social Organization of Policymaking at the Provincial Levels

Having presented the credentials and work policymaking experiences of the standpoint participants, I now turn my gaze to describing the social organization of work within the provincial sites. The questions that this section answers are many, but the purpose of this section is to make institutional mandates, ruling relations, the social organization of policymaking as work, and the social relations resulting from that work visible.

6.3.1 Rules-Driven Legislative Work Undermines Progressive Agenda

Within the institution of the legislature of the provincial government, standpoint participants recognized that the legislative process itself is very rule-driven with unpredictable

work schedules. These attributes mobilize against advancing of HE/SDH due to having a short window of time to respond to certain legislative priorities mostly dominated by priorities of the sitting government. A standpoint participant demonstrated their experience as follows:

> "The legislature itself is a very rule-driven place. There are all kinds of protocols. These rules make it hard for a progressive opposition to make meaningful contributions when their voices are muzzled."

The above quote is from a member of the opposition in a province that is dominated by a Conservative government. The standpoint participants described some of their work processes as random (driven by political pressures) and constantly changing. The everyday work experience within government institutions varies, from debating, tabling a bill, touring the provinces, as well as meeting-and-greeting voters. One standpoint participant summarised their work experience as follows:

> "There's no work today, it's different every day. Whether I'm in the legislature debating or touring around the province, every day is different. The day-to-day work is so varied."

However, one standpoint participant observed that the rules and protocols in the legislative processes have been used by the Conservative (and can be used by any dominant groups in power) to muzzle progressive voices. The implication is that the dominant group in power decides what kinds of questions are asked on the floor of Parliament, and also controls vital information for decision-making. The standpoint participant described their experience as follows:

> "The dominant groups determine how questions can be asked when we have an opportunity to ask. It's very unusual to be in such an experience where one thinks that when you're elected you have access to all kinds of information but because we're Opposition, there's very little information offered. And we have to go digging like detectives and very strict sort of methods by which you're able to do so."

The standpoint participants recognized that within the legislative sites, it is difficult to focus on HE and SDH concepts concretely due to the unpredictable ever-changing work. Furthermore, the progressive policymaker recounted that dominant groups in power may be opposed to HE/SDH concepts filtering into public policies; and that the opposing voice (of progressives) is often denied valuable information needed to demand accountability.

Policymaking as work in the legislature is coordinated by the Order Paper, usually written by the dominant party in the provincial government. Consequently, opposition policymakers have little or no control in how policymaking as work is prioritized and organized at this site. For a province with a Conservative government, the progressive opposition has struggled to advance HE/SDH concepts in policymaking even where circumstances have necessitated so – like the suicide crisis among Indigenous youths.

6.3.2 Coordination of Policymaking as Work

Within the provincial legislative site, the standpoint participants observed that work is organized in a way that the legislators are constantly working with frontline users of services. This valuable encounter allows the legislators and other policymakers to gauge the everyday lived

experiences of people and listen actively to people's everyday struggles. The interaction outside of the legislative council ad with other government bureaucrats is well-coordinated activities that allow the policymakers to interact with community-based organizations, professionals, businesses communities, content experts, and local leaders who are engaged in community life. One standpoint participant observed their work as follows:

> "We're constantly working with frontline users of services to understand that experience and hear what their challenges are, as well as providers, teachers, doctors, nurses, social workers, etc., and businesses. And we're also talking to folks in the labor movement community-based organizations. It's a pretty constant connection with a large number of engaged people."

The quote above references work that transcends the local into extra-local sites, and across partisan foci. The coordinated work described in the above quote allows the legislators to know the everyday experiences of people and the social inequities that they encounter. This work is also extra-locally coordinated to expand the knowledge of the legislators about the scope of inequities and actions being taken to mitigate the impact of inequities in their and other provinces as well as territories across Canada. One standpoint participant described this experience as follows:

> "And I would also rely on a lot of folks around the country who are in the business of promoting HE in various sectors and learning from experiences elsewhere what's working well and what is not."

Locally, the policymaker's work is coordinated intra-locally through interactions with medical officers of health, Ministry of Health and government line ministries that address a particular issue such as housing, access to health care, labour relations, and so forth. One standpoint participant stated it this way:

> "I would lean on both the staff and MOH that I work with those who have areas of expertise. Different critical areas and try to understand, through them, what exactly what is going on so what the current reality is as well as trying to design, more ideal approaches to address challenges."

In sum, the social organizing of policymaking as work at the legislative level extends beyond debating issues on the floor and is hooked to both the work and lived experience of others outside the legislature. The policymakers tend to interact within the institution with professionals and political heads of statutory organizations and leaders in businesses/private sectors to figure out the extent of inequities in society and the actions being taken to address them. The policymakers demonstrated an experience of the interactive nature of work, where they meet people in the community and listen to their everyday struggles. This finding demonstrates that policymakers have the resources to interact with the population, to listen to the people describe their everyday life experiences, and to interact with decision makers, experts, and community partners – business community to discuss and evaluate the extent of health inequities in society. The critical question then is why do health inequities persist and even grow wider when policymakers have the opportunity to interact with the affected communities? Why is it that governments do not apply HE thinking in public policy responses to reduce and where possible eliminate inequities in health

in society? We now turn to the institutional conceptualization of HE and SDH concepts at the provincial level to seek answers to these critical questions. In the next section, we compare and contrast the institutional conceptualization of HE and SDH at the provinces and the federal level.

6.4 Institutional conceptualization of HE/SDH

At the provincial level, HE/SDH concepts are not common in health discourses and, these concepts are considered to be costly for the government to focus on and the concept is not communicated convincingly. Below are some themes that emerged from the data to bring insights into the institutional policymaking process.

6.4.1 SDH is Not Widely Understood

At the provincial levels, the standpoint participants observed that the term SDH as a concept is not widely understood and so is the idea of advancing HE policy for action on SDH. Often, when speaking with decision makers, someone who understands SDH must explain and provide examples before getting a response. Once the examples are provided then decision makers tend to respond or show interest in taking actions to address those gaps in ways they consider convenient or realistic. Here are two quotes that exemplify this point:

> "Simply focusing on identifying social determinants of health isn't sufficient. And I go back to what I had said when I had my really long chats with many deputy ministers and assistant deputy ministers in Ontario, most of them got that."

> "And, you know, and if we call them the social determinants of health, in some ways, they're more difficult to get people to do things than if you don't call them social determinants of health."

The bureaucrat at the provincial levels seems least socialized with SDH concept mostly because of their background in business and corporate world. One standpoint participant recalled an experience where a concerted effort was invested in a discussion about mental health and housing as SDH; and no decision was made. The moment the link between housing and mental health was described with evidence, then decision makers were responsive. Here below is how she recollected:

> "And so if you're specific, and if you say, people need housing, and you will get people taking action. Essentially when we link mental health with housing over time they say, Okay, well we better work on your housing."

The above quotation demonstrates the need to improve how we communicate about actions on SDH by being practical and using everyday examples of the problem we are attempting to solve. While the SDH concept may be well understood and appreciated in some provincial sites of policymaking, internal resistance still exists to the extent that SDH advocates have to explain and justify their causes over and over.

6.4.2 SDH is Costly for the Provinces

The standpoint participants believed that one of the reasons the provincial decision makers evade the discussion around SDH is that they believe it is expensive for the provinces to invest money in reducing the cost and improving the quality of living for its population. One example which stood out was housing. The provincial governments resist investing in housing because they do not want to subsidize housing costs. They also see no connection between health and housing and therefore discourage any linking of health to housing or working conditions. Here is how the standpoint participant summarized her experience:

> "Well, and they don't want to pay for housing, because an immense need for housing is not what they think the [health] industry should be doing, which the Ministry of Health should be doing [paying for housing]."

Another standpoint participant talked about the provincial government's attitude toward efficiency and commissionable savings as the determinant of whether or not to invest in equity policy. The standpoint participant observed:

> "There is an imperative for your efficiency saving to actually make any difference. And so, the problem people have with the cost argument is that you actually have to have what's called commissionable savings for the cost savings account equity to be something that is policy relevant."

From the above, we see that the provincial governments are primarily concerned about the cost of enacting an HE policy to avoid socio-economic resource redistribution.

6.4.3 SDH Is Not Communicated Convincingly

The provincial government and its institutions lack unity in the conceptualization of SDH and therefore the way it is communicated to decision makers from a diverse professional background – probably corporate or business community – often stirs confusion and ambiguity. However, the socio-political environment also has a great impact on how the concept is received, processed, accepted, or subordinated. It is more likely that in a Conservative environment, a superficial understanding is afforded to the SDH concept while under other forms of social organizing, such as Liberals, the depth afforded SDH tends to be more elaborate. Here is what one standpoint participant stated:

> "I would say now there's not a lot of understanding and a lot where they would say that it's more like it was...everything provincial tends to be very Conservative organizationally to get this very deep understanding of what the determinants mean. Maybe not Conservative on every topic, but essentially, maintaining their Conservative identity. I think, given that context, it's not the same as it was 10 years ago 12 years ago 15 years ago on HE."

Another barrier to communicating SDH is a lack of awareness of other professionals about how their actions directly or indirectly constitute, contribute or undermine SDH. One standpoint participant described her experience as follows:

> "We get these very different professional backgrounds; all fully understand what inequities or inequalities were once it was explained because there are sometimes where we don't know

whether they are healthy or not health professionals. I would say, no, but the work you've been doing as a lawyer as a child advocate…those are all determinants of health, those are all health promotion."

In sum, at the provincial sites of policymaking as work, the striking semblance to federal-level work experience for policymakers is the ambiguity in communicating HE/SDH concepts. One reason for this is the institutional conceptual practices of power – the idea that health is about disease and germs. The other probable reason is that at the provincial level, administering universal health care is a major priority. Therefore, any considerations of SDH as recommended by the 2008 WHO Commission on Social Determinants of Health – that much of what causes poor health in a population is found outside the health care – is resisted. The third probable explanation is that the corporate interest in health care and the expansion of neoliberalism at the provincial level obscures the need to think upstream. Lastly, a potential explanation could be that the Conservative ideology resists the government's role in the redistribution of social and economic resources in society. Thus, the decline in the redistributive effect of the welfare state system does not preclude the role of actors at the provincial level where key public policies could mitigate social inequities. In the next section, we examine the institutional conceptualization of HE. I shall compare and contrast the conceptualization at the provincial level with that of the federal level.

6.5 Institutional Conceptualization of HE within the Institution

Within the provincial government circles, there is an understanding that HE is an object of public policy. However, the ambiguity over the concept of HE persists and there is no consensus on what HE is. In addition, HE actions target a population, and overall, there is a gap between

what the government says it wants to do to mitigate health inequities and what it is actually doing. Below are some themes that emerged.

6.5.1 HE as an Objective of Public Policy

The standpoint participants acknowledged that there have been many discussions about equity and their health impact on the population at various platforms and political levels in the provinces. This demonstrates that indeed, within the provincial governments, HE is considered an objective that public policies should achieve. One standpoint participant summarized her experience as follows:

> "There has been a lot of discussion about equity and their health impact and the HE impacts assessment that was developed by the Liberal government at provincial level"

It follows that in Ontario and Saskatchewan, the Conservative government replaced governments that invested resources in developing infrastructure and policy frameworks supportive of HE. One standpoint participant made the following observation to support the argument that the Liberal government was more in pursuit of HE than the current Conservative government:

> "If you look under data and analytics, there's the HE tab. There is one for SDH. And then there are also HE indicators, there is a report on HE indicators. I hope you can find it there somewhere. I would say that that group was your balanced group. There was a very good deep understanding of HE in the past government."

Here, we see that both provincial and federal governments acknowledge that social inequities have a profound impact on the health of Canadians and that HE should be the object of public policy. However, this concept is sensitive to the politics of the time. Conservative thinking seems least accepting of HE while Liberal politics seems amenable to it.

6.5.2 Ambiguities on HE Concepts

At the provincial policymaking sites, policymakers grapple with multiple conceptions of HE. In some worksites, HE is used as a lens through which to appraise government programs. When taken as a lens, HE is also used in designing public health programs, and in identifying drivers of social inequities. Here are two quotations that summarise this argument:

> "When critiquing the policies of the government in power, we do so always with an equity lens. What's the fairest way to do things? And what's the way that will have the most positive impact on health outcomes with the population; say in the reserves, would always be, to and to those most in need? That is a lens that we take to the critiques we bring and the policies we discuss."

> "We introduced HE into the framework [Indigenous]. An equity lens, by which we mean that when you're developing public health programs to address various public health issues, you have to apply an equity lens, think about where the inequalities are here, and how do you address them. In every program. Now, the languaging was interesting and challenging because we had a so-called Liberal government here, which was anything but Liberal."

While this group demonstrated an understanding of HE when used as a lens through which to formulate, shape, and implement provincial health policy, programs, and innovation, the standpoint participants were also aware of the constraints that the political environment placed on the concept.

Other policymakers within the provincial government have encountered the HE concept simply to "access". One standpoint participant had this to say when asked about applying the HE concept in policymaking practice:

> "I've always been very concerned about groups that didn't have as much access to resources for various reasons, which we all know."

Another standpoint participant, who reiterates the stigmatizing institutional practices of targeting a population, had this to say:

> "So, we can say that a particular grouping requires more and more intense focus to address some of the structural barriers, for example, access to healthy food for Indigenous people that need to be addressed"

While access is an important aspect of HE, the concept cannot be reduced to access because it undermines the other important moral or ethical undertakings that HE commands. In my professional experience, I participated in a revitalization of a poor neighborhood in Toronto. One of the features of the revitalization was building a state-of-the-art swimming pool. The community

has access to the pool. However, to access the pool, immigrant families residing in the community were required to reserve the swimming time or slot for their children or themselves online.

Unfortunately, most of the residents who should have benefited from the public pool lacked internet access, hardly read English, nor possessed a working knowledge of how to do online reservations. So, they had access to the pool, but they could not actually use it given the systemic barrier at hand. It turned out that residents from wealthy parts of the east end of Toronto were using the pool more and the area residents could only passively stand from outside to peep through the glass walls to admire the children of the rich and their parents enjoying swimming in the pool. This real-life story provides a clear example where HE should never be reduced to "access".

Other policymaking worksites within the provincial government simply consider HE as imprecise and not easy to understand or to be communicated effortlessly. Below is a quote that summarises this concern and frustration over working with HE concepts:

> "One misunderstanding is that it is [HE] a concept that has a couple of steps to it, so it's not a simple one- or two-word slogan that makes that so easy. People understand that the way that things [HE] are reported makes things a little harder to get those messages across. There is impatience among my own colleagues that they want us to have clear, simple messages. Those are what people are asking for now. And it is frustrating with this sort of shift where it takes time to grasp."

Furthermore, the ambiguities surrounding HE have a conspiracy tinge to it. Some policymakers reject the concept as a form of a demand for governmental accountability. Here is what a standpoint participant had to say:

> "The problem with equity has been trying to decrease the gap between what governments say and what they intend to do."

The above short quote summarises what the policymakers know is happening within the institution – that persistent lack of commitment to HE. In sum, just as it is at the federal level, the ambiguities surrounding HE concepts persist at the provincial level. However, the possible explanation for this ambiguity could vary between the two policymaking worksites. One notable point is that at the provincial levels, the worksite selected for this study was not embedded within the health sector because potential participants declined an invitation to be interviewed. Second, those active in policymaking in the legislature or non-governmental organizations may not have the qualifications, experience, and commitment to HE works.

6.5.3 HE as Targeting a Population

The standpoint participants identified policy work to promote health equity at the provincial levels as targeting the population as opposed to system change or narrowing the gap (Graham, 2004). As such, they described a practice where policymakers would examine a population for certain disadvantages and then plan an intervention. Some of the interventions may be one-offs or run for a very short time without depositing any tangible outcomes. This is what one standpoint participant had to say:

> "We looked at particular populations who might experience additional challenges and need additional approaches to try and meet their needs. So, it's been a constant theme within my work and sort of it in terms of my role and as a champion."

One standpoint participant delineated the difference between actions that are designed to target a population from those that are designed to apply HE. This is what the standpoint participant said:

> "When you go back and look at public health reform in the mid 19th century. And the reason for it was because of the massive inequalities in health but very high infant mortality rates, very low life expectancies in the analysis of the health of what is called the laboring classes in Britain in the 1840s. So, they were focused on inequalities in health. I think they didn't call it HE, but they were focused on inequalities in health 180 years ago".

The above quote provides a solid argument that when actions are taken to target a population, it may miss out on some important markers of inequalities in health. In sum, just as it was the practice at the federal level to target the population, provincial policymakers pursuing HE continue to use the concept to target a population.

6.5.4 HE Pursuit as a Performed Act (Performability)

There exist conflicting perspectives on whether the provincial government is pursuing HE with any commitments. These conflicting views were common among standpoint participants who are outside of the government. They believe that what the government says it will do or not do,

should translate into tangible outcomes for equity to be seen. For instance, when the government says it will reduce poverty but poverty among children and women is increasing, they consider this diabolical and purely political. One standpoint participant had this to say:

> "There has rarely been a proper attempt to produce HE [provincially] policy. From the federal level [to the province] they have been playing politics and they've gone down the line Gender-based analysis of gender-based policy, but they haven't got into equity policy in the way they should."

Another standpoint participant believes that the governments have a tendency of talking about HE and yet their real policy is that of inaction in pushing for HE. This is how she explained her understanding of the actions of the provincial government on HE:

> "…it doesn't really matter even if you did even if you had a very strong political statement on achieving equity in health policy. A policy is not what governments say the policy is or what governments do. The policy is also what governments don't do. So, they may say, HE, but they may say we're going to eliminate poverty, child poverty. But if they didn't do anything about it, then all you've got is a nice bed of empty words."

Another standpoint participant who has worked with the provincial government in various capacities spanning decades also cast doubt on the provincial government's efforts towards HE as follows:

"For most people within the institution, equity has not been a focus, poverty may have been a focus, but equity is not."

In sum, there is a doubt in the minds of people who work within the provincial government, and those who work from non-governmental organizations but support the work towards HE for the redistribution of social determinants of health, that the provincial government is committed to the pursuit of HE. The standpoint participants believe that the government applies a non-action policy on HE even if it publicly expresses intentions to pursue, HE. The lack of commitment to actions on HE at the provincial level is strikingly similar to practices at the federal level and may have similar explanations that the dominant institutional conceptual practices are those that favour social positivism (Aggleton, 1990; Shah, 2003).

6.6 Institutional Values Governing HE Work

The findings presented above which depict the provincial government's efforts to pursue policies that promote HE/SDH as lip service is not new. A similar sentiment was found to characterize HE/SDH policymaking commitment at the federal level. The standpoint participants identified several institutional values and practices that govern their work on HE/SDH policies within the provincial institutional settings.

6.6.1 HE/SDH Policymaking Work is Sensitive to Politics

The standpoint participants acknowledge the impact of politics in advancing the work on HE/SDH at the provincial sites. The influence of political ideology on HE/SDH at the provincial site of policymaking is particularly visible and intense owing to the provincial mandate of

delivering health care. During my interview, the Conservative government was in power, and therefore, the policymakers that I had identified as potential sources of data declined to participate due to the political sensitivity. However, those who participated were able to recognize political ideology, especially of the Conservative, as not very supportive of HE/SDH policy work. One standpoint participant had this to say:

> "And then, of course, the government of the day was being Conservative. The government doesn't have an equity focus. They're very resistant to that type of approach."

Another standpoint participant recognized that the Conservative government has an industrial corporate vision, which, in many ways, is associated with investing less in people and focusing on businesses. The standpoint participant had this to say:

> "The vision of the current Conservative government is not a vision of crawling together and investing in people. It's very much industrial corporate vision which means they want occasionally, on occasion will give lip service to investments in the future that barriers to actions don't show that."

The standpoint participants reveal that working in institutions dominated by political ideologies of the right is always intense and complex. Standpoint participants confirm that such ideologies are hostile towards HE and SDH work. One participant described this complexity as follows:

> "It was a kind of amalgamation almost a takeover of the BC Liberal Party by the social credit Party, which is a right-wing party. And so, it's a kind of uneasy alliance a bit like you're seeing federally now with the Conservative Party, an uneasy alliance between from Progressive Conservatives and some very sort of hardcore almost Libertarian Conservative. And that was the government of the day. And so, you couldn't even get them to use the word equity. We ended up talking about disparities."

The standpoint participants often felt that the challenge of HE and SDH concepts is not something that individuals within the political ranks do not understand. On the contrary, the standpoint participants narrate experiences where individuals actually get the concepts in a small group discussion or on round tables, however, the moment it comes to collective responsibility, like voting along party lines, then these individuals would vote against or take the unpopular position that deliberately suppresses, subverts, or resists the focus on HE/SDH. This is what one of the standpoint participants stated:

> "I dealt with all councillors at the City and Politicians at provincial level but anyway dealt in discussions of HE/SDH issues, one on one or in small groups they understand it. But in terms of collectively, I don't know if even people are talking about this kind of thing (Health Equity). I somehow doubt it at the provincial level, given the people who are now in power."

In sum, at the provincial level, HE/SDH concepts in policymaking are very sensitive to the political ideology of the dominant group in power. While some policymakers believe that their institutional focus is on HE – trying to improve health through HE and SDH – the politics of the

day is the key determinant of progress in achieving HE/SDH policy. Understandably, the Conservative group in Ontario seems not amenable to big strides towards addressing health inequalities and inequities through HE public policy.

6.6.2 Persistence of Individualism and Culture of Accumulation of Wealth

The policymaking sites at the provinces have retained and pursued policies that favour individualism and those that promote the accumulation of wealth in the hands of few individuals. One standpoint participant attributed this culture to Western industrial capitalism whose focus is to define growth as progress; being wealthy is good, being wealthier is better. Therefore, more individuals are focusing on wealth accumulation and would do anything to undermine public policies that address unequal distribution of social, cultural, economic, and even political (power) resources towards an equitable society. The standpoint participant had these to say:

> "So, what we have is, culturally, the Western industrial capitalist culture, says that growth is progress being wealthy is good being wealthier is better. Having stuff is good having more stuff is better (accumulation)."

> "So, bigger is better. And that's really a sort of profound cultural value, making money, etc., and then on top of that, you have. I guess I call it a cult of individualism, which is particularly coming out of the United States but has always been there to some extent. And that individualism is more important than the collective."

Drawing on from the infamous 1980's pronouncement by the UK Conservative Party PM, Margaret Thatcher, that there is no such a thing as society, the standpoint participant attributed the pervasive social inequalities at provincial levels to such an entrenched culture that embodies individualism and private wealth accumulation policymaking at the provincial level. The standpoint participant articulated it this way:

> "And you can take that to extremes, so you have Margaret Thatcher thing there's no such thing as society. So, I think that route to what we're talking about is that the social determinants of health and inequalities in health are rooted in some profound cultural values"

In sum, the cultural values that are entrenched and dominant within the provincial institutional sites of health policymaking are pro-individualist approaches. This thinking characterizes the institutional conceptual practices in undermining policymaking efforts aimed at transforming the system. There is resistance in ensuring that social and economic resources are redistributed fairly through equity-guided public policies. As I shall gradually demonstrate, the province has many health-equity programs and tools at its disposal that are not deployed. However, these programs and tools are sharpened to address individual lifestyle and coping skills as opposed to addressing the SDH.

6.6.3 Policymaking on HE Gets Displaced with Emergencies

The standpoint participants at the provincial sites identified that work on HE gets easily disrupted with changes in the political environment or emergencies. Within these institutional worksites where the focus is on scientific advice, priorities may shift from time to time to other

areas that present strong evidence for action. During the pandemic lockdown, HE was not an issue until the effects of the pandemic made them visible. The standpoint participant had the following observation to make:

> "And so, our priorities are dictated not with the same common goals. We relate the priorities in the system with the priorities of the Public Health Unit. In the last few years, we've been very lucky that there has been a greater focus on HE. But, you know, currently [under the Conservative regime] it's all just rolling up our sleeves and getting through the coronavirus outbreak.

Another standpoint participant was bold enough to state that at the time of the interview, when coronavirus lockdown measures were just rolled out, HE conversations were not being held. This statement exemplifies the theme that HE/SDH concepts may not be considered as a primary core area of public health. When a calamity (health security), pandemic, and other emergencies arise, HE/SDH considerations are displaced or dropped from the policy agenda. This is what the standpoint participant said:

> "I'm trying to say in terms of barriers, a barrier to taking a long-term view [actions] of HE is really our mandate, our mandate is to provide scientific and political advice to the provincial decision makers. It really depends on what the priorities are, and currently [with COVID-19 Pandemic] the priorities are not HE. It's really addressing the tremendous risk of coronavirus and its population."

In sum, the institutional practices subordinate the concept of HE in public policy and undermine efforts at obtaining policies for the redistribution of social and economic resources equitably. At the provincial levels, HE/SDH concepts are not considered a core public health function, and policy work on advancing HE/SDH is always displaced during emergencies or when the political environment changes. We have seen that HE is sensitive to political ideology at the provincial policymaking sites. These findings are similar to the experiences that standpoint participants enumerated at the federal level. At the federal level, I found that HE/SDH was considered typically a core public health role but not afforded the same commitment its pursuit as stated in the government's rhetoric. Thus, HE/SDH policy work is easily displaced by emergencies and other priorities considered a public health core function.

6.6.4 Resistance from Institutional Bureaucracy

The bureaucratic architecture within the provincial institutions of policymaking is reputed for resisting the HE/SDH concepts of HE like it is at the federal level. Standpoint participants identified low levels of understanding of the concepts of HE/SDH among the senior levels. The standpoint participant had these to say:

> "And I interviewed many different ministry deputies in the province. And there was a very poor understanding at that senior level of like health promotion and what the determinants of health were and what their departments could do in their ministries within context."

The roles that senior-level bureaucrats play in making decisions to advance or disrupt work on HE/SDH is profound such that if they have a low level of understanding of these concepts, then

we expect a low-level emphasis on promoting HE. One possible explanation of this lack of awareness of HE/SDH concepts could be that the bureaucrats may be conspiring with corporate interests and politics of the day. Another standpoint participant confirmed this argument by stating as follows:

> "At the provincial level when they started talking about equity, we've been trying to convince them that equity equals quality, and the aim should be to match resources to needs. However, it has been very difficult to get that done because of the way the provincial level is organized politically."

The resistance offered by bureaucrats within an institutional site of policymaking affects how health services and programs are designed and delivered provincially. Bureaucrats at the provincial level, especially in Ontario, explicitly favoured corporate/business role in health policymaking. This action is geared towards promoting marketization/corporatization and the accumulation of wealth in the hands of a few. Their market proclivity is opposed to health equity that seeks to reduce social inequities through HE policies. Standpoint participants narrate experiences at work in which bureaucrats align themselves to hold on to positions of power and prestige, and this is not surprising. Such an arrangement would not allow the concept of redistribution of resources, say from taxes through education, health, infrastructure, housing, and so forth to happen under their watch. One standpoint participant demonstrated it this way:

> "There's the combination of maintenance of power. They want to stay in a position to make decisions, and they are economic first, and economics is extremely important, a strong

economy is absolutely foundational to our ability to provide what people need from a health point of view. But that's not their measure, they don't see it as a tool for a greater goal, it is their goal, in and of itself."

In sum, the policymaker's everyday work experience at provincial sites of policymaking is to overcome resistance to the HE/SDH concepts. The resistance is attributed to the institutional bureaucratic architecture, politics of the day, economic interests, and the need to maintain power. In response, policymakers spend time devising means to navigate through that resistance by educating decision makers and at times renegotiating the place of HE in health policy, contrary to the much-acknowledged relevance of these concepts publicly. Senior management level actors are a powerful force in deciding the direction of HE policies. In the provincial site of policymaking, the senior management tends not to have the orientation in HE and SDH concepts. This may require a lot of ongoing education, convincing, and where possible even demonstrating how health inequities make people not enjoy the high quality of a healthy life.

6.6.5 Reorienting Public Health into a Disease Management System

One of the most contentious issues that need settling is the relationship between disease management and public health in the sense of health promotion, HE, and SDH. In speaking with the standpoint participants, a common theme of concern over the public health system being increasingly organized around managing diseases and not addressing the social, economic, and power inequalities emerged. The standpoint participants recognized that the health system is increasingly oriented to disease management which makes it difficult to anchor HE/SDH in the same realms as disease management. One standpoint participant stated as follows:

> "It was looking at how you could refocus interventions on chronic diseases. To not simply be about treatment but how you could begin to adjust. So, you could impact chronic diseases, either mitigate the development, you know prevented or mitigated all began outside the health care system, but the fallback was always to disease treatment as opposed to prevention of disease."

Another standpoint participant took exceptions with the [Ontario's] provincial decision to transform public health units into public health authority in what they considered a move to undermine progressive public health systems and redirect it to disease management. The standpoint participant felt that the creation of health authorities was a political manoeuvre to reduce expenditures on public health by further integrating public health and healthcare system. Accordingly, the province directs public health focus on disease management as opposed to the much-desired disease prevention and socio-economic inequity reduction. This is how she summarised the situation:

> "One of the things that I think has been really bad has been the absorption of public health into health authority, which has happened in Ontario now and other provinces, I think it's a huge mistake. Because health authorities are really not health authorities any more than the Ministry of Health. They are the health ministry. It's the Ministry of Illness Care, and the health authorities are illness care authority. And that's how they think and so they don't get public health, they don't value public health unless there's an epidemic"

Other standpoint participants reiterated their concern that public health function in its real modern sense has been reoriented to managing health securities - emergencies, epidemic, and pandemic response. The policymakers see that transforming the public health units into health authorities has created a system that directly undermined public health and all its good upstream work. This is how she summed it:

> "When the push comes to shove everybody wants to protect their own turf. And there's a lot of money in health. It is 47% of the budget. So, it's hard for hospitals to even think about the community, which is where health promotion and health inequities are really addressed and not addressed inside the hospitals. Therefore, I was very upset when they created the LHINS. And the only criteria they used to establish the geographical patterns, was hospital utilization. That was the criteria they used to create boundaries. And so, you know, to me that said, the LHINS was going to be institutionally based."

Arguably, policymakers at the provincial institutional sites demonstrated concern over the reorientation of public health functions towards disease control. In particular, standpoint participants in provinces with Conservative governments felt that reorganizing public health for all reasons other than strengthening it only undermines the system by enhancing the commodification of health care. According to the policymakers, the reorientation of public health to disease management undermined policy work to address social and economic inequities which are increasingly becoming more burdensome to the health of Canadians. For instance, in the case of Ontario, the official government public health website describes Ontario Public Health programs as follows:

> "Ontario's public health programs focus on disease prevention and control, screening for health conditions, and public education on health matters such as communicable diseases and healthy living." (Public Health Ontario, 2020).[28]

6.7 External Influence on Policymaking as Work within the Province.

In this section, I briefly examine the external influences that shape the conceptual practices within the policymaking institutions across provinces. Conceptual practices refer to the concrete or material practices in which people engage together with the social relations that connect them (Bisaillon, 2012). The ontological commitment in institutional ethnography is the assumption that ideas and concepts emerge through people's material practices (Bisaillon, 2012; D.E. Smith, 1990). Policymaking as a process and people's activities concerted as such, does not occur in a vacuum rather in spaces and places where people's actualities are derived.

Therefore, it is risky to assume that all activities that constitute policymaking are without interests – both internal and external. It is thus best that we examine external influences or countervailing forces that influence policymaking. During the data collection, standpoint participants spoke about these influences, namely the corporate/business sector, political ideology, interaction with the labour movements, and civil society organizations. The multiple manifestations of these forces combined to shape the everyday work experiences of policymakers on HE/SDH profoundly at this level of government. Campbell and Gregor (2008) draw attention to the roles that external forces play in shaping institutional sites of policymaking activities.

[28] Public Health Ontario (2020): Ontario Public Health System: Chief Medical Officer of Health. Retrieved on May 22, 2021 from https://www.publichealthontario.ca/en/about/blog/2020/ontario-public-health-system

Campbell and Gregor suggest that the social organization of work may encompass those social relations that connect the local setting and local experiences to sites outside the experiential setting.

6.7.1 Corporate/Business Influences

Several themes emerged when identifying corporate/business sector influence across the provinces. These influences were more pronounced in Ontario; however, the role of corporations was visible in both favourable and suspicious terms as highlighted in the subsections below.

6.7.1.1 Corporate Influence is Dominant

Contrary to the everyday work experience of policymakers at the federal level where their encounters with corporate/business influence were benign and often unrecognized, and such interaction with business/corporate influences considered to occur at a higher political level, at the provinces, this is not the case. Standpoint participants describe their everyday work encounters with corporate/business influence as overt and often lurking in every aspect of their work activities and every site of policymaking. One standpoint participant stated as follows:

> "At the province, corporate interest lurks, I think it's up to the government to really start redefining what businesses in the future and how they get rid of the excess in big business. If they really want corporate responsibility to, to try to improve HE."

This standpoint participant recognizes the looming presence of corporations, corporate interests, and its potential capture of the policymaking process due to fused boundaries. The standpoint participant is concerned that the provincial government should redefine these

boundaries to set a clear agenda for corporate/business actors in HE policymaking. Another standpoint participant reiterated the above revelation by stating, and I quote:

> "Corporate influence in the framing of the policy agenda and policy goal. Absolutely. And they don't even hide it as a positive thing."

The above quotation demonstrates the visibility of corporate influence at the provincial sites of policymaking. The active presence of corporate influence has a direct negative impact on efforts to promote HE and SDH. Corporate interests highlight the flourishing of private ventures as vehicles for financial and business elites to accumulate power and control and a threat to cosmopolitan democracy as they often hijack the voices of the people (Boggio, 2012). The increasing corporatization of the institutional worksites pervades the policymaking experiences and extends to the health policymaking worksites being increasingly governed by corporate leaders. One standpoint participant demonstrated that the various boards within the institution of health policymaking at the province are headed by people from the corporate sector. The standpoint participant demonstrated the above as follows:

> "Among corporate leaders, I think the system is such that, the corporate leaders spend time with corporate leaders in the various boards. And I think, you know corporate boards are all full of corporate people. And that explains the biggest inequities in society right now and it's associated with income disparity."

The standpoint participants recognized the overt presence of corporate influence and how it filters into the policymaking processes and activities. This observation is particularly important in light of the impact of political ideology on HE, and the structure of power within provinces.

6.7.1.2 Corporate Role is Necessary when Controlled

The standpoint participants were reflective when I spoke to them about the role of corporations in influencing HE policy. While being critical of the influence of corporations, standpoint participants recognized that corporations/businesses have a role to play in shaping health policy and achieving some of the goals through their innovative capabilities. The standpoint participant had this to say:

> "I see that it's really important to speak to businesses and to speak to them in language that is relevant to what matters to them, which is that community well-being does matter. It's also important to talk to them in terms of the bottom line that their business will do better in a society where more people can afford a decent standard of living and make like making the business case for HE as well."

The above text is a recognition of the potential contribution of corporations/businesses in an environment where the rule and ethics are well set out by the government or authorities. The standpoint participant is arguing that an equity principle should be the guiding principle for the participation of corporate/business actors. The boundary was deemed relevant to clearly define the role of corporations in partnering with public efforts towards achieving HE/SDH policies. Corporate interest already influences HE/SDH policymaking directly and subtly through social

corporate responsibility and other innovations. Recognizing these roles would ensure that corporations/businesses see their roles beyond the narrow approach of profiteering. Indeed, in challenging ways provincial governments are failing to regulate corporate/business influence in shaping institutional conceptual practices on HE, one standpoint participant stated as follows:

> "The point of government is supposed to produce an environment in which business works. All businesses have to pay more than the competition if the corporate responsibility and community responsibility were written into what is expected from corporations if they're going to do business in the province."

This quotation reveals that the provinces have not done enough to draw the line between politics and business interests. The practice has allowed corporate hegemony thereby permitting a situation where corporate capture of public policy agenda is possible through politics and unfettered social corporate responsibility (Burke & Logsdon, 1996; Hillman, Kein, Schuler, et al., 2004; Miller & Harkins, 2010). While the standpoint participants recognize the role of corporate/business in shaping HE policies, they encounter instances where these roles are not tamed or properly defined.

6.7.1.3 Corporate Roles Could Transcend Profiteering

The standpoint participants attested that when performing their work as policymakers, there is always a challenge of understanding the role of corporations/businesses. This role confusion needs clarifying at the multi-sectoral platforms and other round tables where collective efforts are needed for innovations. The clarification would safeguard the population against corporate

profiteering, market-oriented political interests and would also ensure that people come first before profit. The standpoint participant observed as follows:

> "So, you do need to look at what ethics the different businesses are pursuing, and definitely we have in the Conservative movement, a tendency towards business first people second, if at all."

The above quotation links the Conservative ideology as supportive of the corporatization of the institutions and their policy outcomes. However, other standpoint participants alluded to corporate actors whose aim is to bring competition within the policy itself to ensure that such policies are tailored to favour them over their competitors. In this scenario, the people are alienated from the objective of the policy, and yet the policy affects the people. One standpoint participant alluded to the competitive nature of corporation in the policymaking process as follows:

> "They're those corporations that hate fellow stakeholders and are perfectly happy to see legislation that will make life more difficult for others, because it makes life better for them – lower taxes, less environmental regulation plus social regulations, etc."

The standpoint participants have presented insights into their encounters with the corporate/business sector while making HE policies in various sites and over time. While the standpoint participants recognized the commanding presence of corporate/business influence over public and HE policymaking, they also recognized that corporations/businesses have a role to play and it is the responsibility of governments to clarify their roles, set the rules of engagement, and

protect the population from the profiteering agenda of corporations. When corporations, which have mostly worked in health policy realms for decades, are oriented to HE through regulations, their social corporate responsibility could address health inequities. As Cambell and Gregor (2008) observe, standpoint participants are the expert in doing what they routinely know how to do. This implies that the reflective narratives of policymakers capture their actualities and conceptually embody their everyday work experience over the decade.

6.8 The Influence of Political Ideology

At the federal level, we found that HE and SDH concepts are sensitive to the politics of the day. Standpoint participants identified the Conservative political party as being least inclined to embrace HE/SDH concepts in policymaking. Although the Liberal party's equity agenda was identified as a favourite, both parties pay lip service to HE policy work to advance action on SDH. In this section, I present the standpoint participants' work experiences with external influences, namely political ideologies, labour movements, and civil society organizations.

6.8.1 The Influence of the Conservative Ideology

At the provincial level, we see that the Conservative Party overtly opposes, undermines, subverts, and subordinates HE concepts from health policy. This is partly owing to the Conservatives moving towards a market-based analysis of needs and tax cuts to businesses, which means money flowing to the rich. One standpoint participant had this to say:

> "I believe that since the late 80s early 90s, the Conservatives have moved towards a market-based analysis of the needs, which has meant that increasing amounts of money are going to the rich people and businesses, who get smaller and lower tax base."

The above quotation implies that HE and corporate interests are mutually exclusive of each other. The rich hardly wish to redistribute their accumulated wealth and when they have to, they connive with the government that lowering taxes would enable businesses to keep high levels of employment – albeit precarious jobs, low paying, and exploitative. The standpoint participants further recognize their work experience under the Conservative government when most of the values of Canadians, such as stable families, fair taxation with the goal of redistribution, and good medical care to support Canadians were all declining.

The standpoint participants reflected that under a Conservative government, low levels of inequities were always defined by those who were least economically viable while not paying attention to other factors outside the economy, such as classism, sexism, and racism that disadvantaged many Canadians. One standpoint participant summarized this as follows:

> "Under Conservatives, lower amounts of inequity in Canada was always based on the least economically viable. Equity was always based on family, taxes, the need to redistribute wealth and medical to soften the differences between rich and poor, and to a certain extent, that work has been decreasing over time under the Conservatives."

Lastly, standpoint participants described situations where the Conservative Party created a work environment intolerant to critics and dissenters. One standpoint participant reflected on a

project that was developed jointly with seven partners resulting in the Canadian Homeless Guide. However, that report was never displayed or made visible to the public for scrutiny. The document was also not made available to anyone labeled a critic. This is how the standpoint participant summarized her experiences as a policymaker:

> "In developing the Canadian homelessness guide...we were seven partners. But that report wouldn't be visible to the public. It wouldn't be visible to anyone who's making a critique. I can tell [that] this political group, so far, has been based on monetary policy and market policies, and then really expect them to deliver equity in the world as we know it?"

In sum, the policymakers recognize that the Conservative political parties and their affiliates are hostile to HE/SDH concepts. This is partly due to their focus on market-oriented policymaking, their tendencies to lavish the wealthy with more wealth by lowering taxes, undermining the redistributive functions of taxes and the welfare system, as well as undermining the health care system. Furthermore, the Conservatives have tended to apply a market-based needs analysis of the needs of Canadians, which favours the monetary policy among others, and therefore is not expected to deliver HE.

6.8.2 The Influence of Liberal Political Ideology

In assessing the role and policy intentions of the Liberal party, the standpoint participants reflected on their work experiences when the Liberal party was in power. The standpoint participants observed that the Liberals may have legitimate interests in pursuing HE and SDH through public policy. This observation contrasts with the Conservatives who did not appear to

understand or make efforts to demonstrate appreciation for HE/SDH concepts. The standpoint participants were asked whether the Liberals legitimately supported HE/SDH as key policy objectives in the decades they served as policymakers at the provincial worksites. The standpoint participants had these to say:

> "If you speak to the Liberals, they may have interests in the issues (HE/SDH) and when you speak with Conservatives, they don't even really recognize the word social determinants. And you have to be more specific."

> "The main problem is there are conditions at all levels of government that recognize SDH, the problems are in the intentions to implement policies and the change that tend to be incremental or business as usual or anything they need to do to get re-elected."

> "In theory, yes; in practice, no. But you would have thought, and I thought that once the Liberals returned to power, they would revive the importance of the public health agency then restore the chief public health officer to be president. None of that happened. And I think they paid in many ways less attention to the Canadian Council on social determinants of health and the Conservatives."

While the Liberals may in theory acknowledge that social inequalities are widespread and that actions on SDH require robust HE policies, their actions and commitment to achieve these policy goals does not measure up. The standpoint participants argue that if the Liberals were committed, they could be reversing Conservative-era policies that undermine policy work on HE.

6.8.3 The Influence of Left-Leaning Political Parties and Organizations

In analyzing the role of the left-leaning political parties, the NDP has not been in power for a long time in the province of Ontario, however, the NDP party has governed Saskatchewan and British Columbia more recently. The last time the party was in power in Ontario was from 1990 – 1995 during a recession under the lead of Bob Rae. As such, standpoint participants in Ontario were less likely to refer to the role of NDP. Generally, however, the standpoint participants recognized that the influence of the left learning political organizations as weak, and that the left struggles to pull together a coalition across the political spectrum and are easily marginalized. One standpoint participant observed as follows:

> "The people who possibly would do that to the NDP are very poor at pulling together a coalition across the political spectrum. They are always about their support. And they're easily marginalized. They could be really important."

Overall, work on health policy with a focus on HE is sensitive to the politics of the province as much as it is to the federal level. Broadly, political organizations of the left have been unable to galvanize their public support; or advance their preferences in public policy evenly across the country. The policymakers agreed that left-leaning political parties are better placed to pursue HE/SDH in public policy to restore the declining redistributive effect of taxation, health care, education, and the welfare state. Additional studies should be conducted in Saskatchewan and British Columbia to evaluate their HE policies and action impact on SDH.

6.8.4 The Influence of the Labour Movement

The role of labour movements in mediating HE has been enumerated by various scholars (Brady, 2007; Tompa et al., 2016; Tremblay, 2016). In Canada, where the main focus of HE lies in employment, work conditions, and income, labour unions play a critical role in shaping HE/SDH discourses. And yet, at the federal level analysis, the standpoint participants did not report direct encounters with unions in their everyday work. At the provincial level, however, the standpoint participants acknowledged the visible and enduring role of labour unions in influencing their work on HE.

The standpoint participants identified the labour movement as an important constituent in the struggle for social justice. The standpoint participants recognized that labour unions are no longer as strong as they used to be in the province and therefore tend to exert less influence over HE policy. The standpoint participants captured these developments in the following quotations:

> "Labour unions are a constituent part of the struggle for equity. It's an important voice and secondly, labor matters. It's not as strong as it once was."

> "The problem is one – unionization has been decreasing year on year for the last 20 or 30 years and is at around 19%, and the vast majority of people here in unions are in public jobs."

As labour unions are declining in the province, the standpoint participants recognize that the largest pool of unionized workers are in public sector jobs while union membership has declined in the private sector. Below is one quotation that succinctly captures this challenging situation for unionization in the province.

> “There’s been an increase in the number of people here in unions in public services, and there's been a decrease in the number of unionized workers in the general population, and that affects youth and families, and I have had real, actual struggles with union limiting activities on HE.”

At the provincial level, not only have unions declined in number, but they have also declined in influence over equity policies, thus making their influence over HE peripheral. Some standpoint participants attributed this fate of the unions to their rather Conservative nature. The standpoint participants observed that unions have held on to their traditional role of protecting jobs and the workers. By protecting jobs, unions are expected to ensure that workers get the pay and job market privileges they deserve. These include the working condition that is safe and fit for the kind of work that they do, appropriate remuneration, and job protection or job security (Tremblay, 2016). The standpoint participants attested that because of these foci, unions tended to be slow and reluctant to change, for instance, to challenges posed by the neoliberal phase of capitalism. One quote from a standpoint participant captured this challenge as follows:

> “I did work with professional groups and unions, but it was interesting because the unions because their role is to protect jobs and protect the workers, they can be very Conservative and very resistant to change like getting the city to hire people who worked within the city but spoke Cantonese or they were from Vietnam, or they were from Kampala. It was difficult. That was a big challenge.”

Furthermore, it emerged in my data that some of the unionized workers do not get concerned about equity once their jobs and privileges are secured. The standpoint participants reflected on their work actualities and had the following to say:

> "It's difficult to get people into various union jobs. Once there, they don't spend a lot of time thinking about equity and access to unionized jobs. I hadn't seen very much on that. So, I don't believe they've done as much as they could."

> "I'm not sure how effective it (labour movement) was but the Canadian Council on social determinants of health had Union rep on it. The Canadian Labour Congress and the Conference Board of Canada and the Federation of Canadian Municipalities. So, there was certainly some effort to bring some of those (unions) together I don't think it worked very well. The only place I've seen it really work, I think, is at the Premier's councils in Ontario."

While the labour unions are fading with their influence in the socio-political space, the standpoint participants identified instances in the past, when workers' unions were invited to make an impact. Even when they failed to do so at the federal levels, policymakers at the provincial levels seemed to recognize their impact.

6.8.5 The Influence of Civil Society

The role of civil society in influencing public policy has been long established (Dinham, 2009; Greer et al, 2017)). Greer (2017)[29] identifies the role of CSO as that which can perform

[29] Greer SL, Wismar M, Kosinska M. (2017). What is civil society and what can it do for health? In: Greer SL, Wismar M, Pastorino G, et al., editors. Civil society and health: Contributions and potential [Internet]. Copenhagen

functions where states and the markets are unable to. As such, CSO contributes expertise, ideas, and diverse perspectives. Thus, the role of civil society in health policy formulation is legitimate as it can offer committed and flexible human resources and other resources that government may not offer due to lack of political interests or pushbacks from market forces. According to Greer et al (2017), civil society can act both as ideas vendors and policy entrepreneurs, and indeed policies that have been discussed with or supported by civil society organizations tend to become more credible and readily acceptable in society. Certainly, CSO has its own technical, political, and financial resources that can hold both the government and the markets accountable, support advocacy, and the technical work needed to move HE policy forward to eliminate social inequities (Hassell, Hutton, Barnett, et al., 2020).

The standpoint participants recognized the role of civil society in their everyday work and attested that at the provincial level, CSOs are not active although they exhibit underutilized potential, are disorganized, and therefore exert little or no pressure on the HE policymaking process. The following quotation captures the actualities of the policymakers when it comes to working with civil society organizations:

> "You know civil society is important. It's important because politics is based on people being baited in. I see that anti-poverty groups and labor groups are extremely important."

(Denmark): European Observatory on Health Systems and Policies; (Observatory Studies Series, No. 48.) Chapter 1. Available from: https://www.ncbi.nlm.nih.gov/books/NBK459047/

> "The problem with civil society, in our province is very, very poorly organized. And because it's so poorly organized, it doesn't realize how powerful it is. All political parties are exclusively sensitive to what people say."

> "The whole cabinet realizes that it's really important for people like civil society. Civil Society has never organized itself properly around that equity. And that's why we haven't gotten an equitable society. If they did, then governments would lose fairly quickly, but they don't. And people don't realize if you have the money and the kind of the organization to pull together pressure on the government."

> "You saw recently 1000 people signed a petition, asking the government, they've got to make it [access to health care services] free for uninsured people during this pandemic, and the government changed their position in three days."

The above quotations capture the perceived and actual experiences of policymakers who believe that CSOs have important roles to play in pushing for HE. However, their pressures are intermittent, not well-organized, and at times ephemeral. Unlike the federal levels where we saw pressures from Indigenous and Black communities resulted in an immediate policy change, i.e., the launching of the Indigenous children's education and the Black community mental health funding, this is missing in the province of Ontario. The pressures from marginalized groups such as the anti-homelessness advocacy groups, anti-poverty advocacy groups, food security working groups, faith-based coalitions, and so forth are absent in Ontario. Therefore, policymakers do not

experience sufficient external pressure to demonstrate a strong and urgent need for them to take their commitment to policies that promote HE for the distribution of SDH seriously.

In summary, this section presented the everyday work experiences of policymakers at the institutional sites at the provincial level. The section was concerned with exploring how external forces, namely political environment, the corporate/business influences, the pressures from labour unions and civil society, coalesce to support or undermine work on HE and SDH. The policymakers attested that HE is sensitive to the politics of the Conservative-leaning groups who tend to favour market-oriented policies and needs assessment. The Liberals are accepting of HE as a noble pursuit of public policy goals, but despite performing acts that appear to be tolerant or even promoting of HE/SDH, they axtually pay lips service and do little or nothing concrete to achieve HE policies.

Thus, due to the two parties dominating government provincially and across Canada, we see that the Liberals never actually reverse anti-equity policies of the Conservatives leading to a sustained increase in social inequities. The policymakers acknowledge that the left-leaning organizations are weak, disorganized, and have not demonstrated sufficient capacity to influence HE. The policymakers believe that the left-leaning organizations have the most legitimate interest in achieving an equitable society and renewing the redistributive effects of the welfare state.

The relevance of this section cannot be overstated because public policy is a constellation of activities and interests. The forces that exert the most influence tend to secure policies that serve their interests. I have seen through this study that the province of Ontario, for instance, is moving further into the Liberal market owing to the increasingly strong corporate/business voices. I understood that board members of major government agencies and bureaucracy have corporate/business backgrounds and therefore also have different attitudes towards HE/SDH

concepts. So, tt is no surprise that their privileged positions allow them to influence government policy and support the corporate business sector.

6.9 Local Public Health Organizing in Ontario – A Case Study

In this section, I focus on mapping out relations of ruling that socially organize public health in Ontario as a case study. Ontario was selected over the other provinces due to my personal living experience in this province and having easier access to key informants. It also is the largest province in population. In this section, I explore texts and intertextual relations of ruling. I will attempt to map the effect of each of the main texts – the Health Promotion and Protection Act, 1990 and the Ontario Public Health Standards (the Standards) – to reveal how they organize the structure and regulate delivery of public health services in the province.

For the Standards, my goal is to identify where HE/SDH concepts are made explicit or implicit which may define the province's commitment to or lack of HE/SDH. In Canada, the provinces and territories administer the delivery of health care and public health. The publicly funded health care system focuses on the health of individuals while the public health system focuses on the health of populations (communities) (PHO, 2020). The public health system in Ontario begins with the Provincial Minister of Health at the top, the Chief Medical Officer of the Province, and the public health units with the Lieutenant Governor at council having the oversight functions, as stipulated in the HPPA.

The Ontario Health Promotion and Protection (HPPA) Act, 1990 is the key governing text that organizes and regulates public health structure and functions, while the Ontario Public Health Standards regulates public health programs and service delivery. The OPHS is monitored by the various Municipal Boards of Health – a body constituted by elected municipal politicians and

businesses and citizens' representatives, most of whom may not have any background or orientation to the concept of public health, or HE/SDH.

6.9.1 Texts and Intertextuality: The Social Organization of Public Health Services

In IE we recognize that higher-level texts establish the frames and concepts that control and shape lower-level texts (D.E. Smith, 2005, p. 226). Bisaillon (2012) introduces the boss or governing texts as those that supply the context for what we can see, hear, and know. These texts are authorized through institutional procedures in which specific people are instructed to carry out specific practices (D.E. Smith, 2010 as cited in Bisallion, 2012). Thus, boss texts coordinate organization relations that control how people work in conformity with selective requirements of the boss text (Bisaillon, 2012). D.E. Smith (2005) clarifies that higher-level texts establish the frames and concepts that control and shape lower-level texts.

Intertextuality refers to the relations and interdependence of texts, which are ordered in hierarchies concerning one another (Bisaillon, 2012). In line with IE's description of the boss texts and the higher-order texts, this section offers a brief analysis of two texts that socially organize public health activities across the province, namely, the Health Protection and Promotion Act, which I qualify as the boss text, and the Ontario Public Health Standards which I qualify as a higher-order text. By social organization, IE stretched the idea that people's lives are socially organized to happen as they do (Bisaillon, 2012). D.E. Smith clarifies that social organization depicts the material and reflexive coordination of the people's actions, as observable and reproduced across time and place (D.E. Smith 2005, 2006).

6.9.1.1 Health Promotion and Protection Act 1990

The text that organizes public health in Ontario is the Health Protection and Promotion Act, R.S.O 1990, c.H.7. The Act regulates the management of health programs and services, community health protection, communicable diseases; rights of entry and appeal from orders, health units and boards of health; provincial public health powers, administration of public health, the scope of ministerial powers, and enforcement.

Of particular interest to this study is section 7 (1) of the Act which mandates the Provincial Minister of Health to publish public health standards for the provision of mandatory health programs and services across the province:

> Section 7 (1) The Minister may publish public health standards for the provision of mandatory health programs and services and every Board of Health shall comply with them. 2017, c. 25, Sched. 3, s. 4 (1).

Thus, the HPPA may not necessarily be focused on advancing HE or SDH concepts in its orientation and language. However, the HPPA directs that Public Health Standards to be developed and transmitted to every Board of Health, and the Minister should make the Standards available for public inspection. Thus, the Ontario Public Health Standards is a lower-level text that arises from the HPPA. The regulatory force of the HPPA is derived from the Provincial Lieutenant Governor in council and the Minister of Health under sections 96(1) and 97(1) of the HPPA. The HPPA organizes the structure and organs of public health and defines the roles that actors perform within those structures or institutions. Below, I describe how the HPPA organizes public health

and services in Ontario beginning with the Board of Health, its character, and proceeding to the healthy public policy experts (now a defunct role) at municipal levels.

6.9.2 The Board of Health (BOH)

The Health Promotion and Protection Act, 1990 is the organizing text that establishes the structure for public health to work in Ontario. Part VI of the Act establishes health units and Boards of Health (BOH). In section 48, it establishes the BOH for each of the 34 health units across Ontario. The Lieutenant Governor in council has powers to appoint some members of the Board of Health. However, the council or the territory where such a board may be established has the mandate to appoint and constitute their local BOH of no more than 13 persons. The Act further stipulates the function of such a board in its section 61. Thus, every Board of Health monitors and ensures that public health units are implementing regulations specific to health programs and services, community health protection, and communicable diseases. An additional role of the Board of Health is stipulated in section 62 of the Act as to appoint a full-time medical officer of health and one or two associate medical officers of health for a jurisdiction. The medical officer of each public health unit is accountable to their BOH.

6.9.3 The Medical Officer of Health

The medical officer of health (MOH) is the chief executive officer of the public health units, all staff is accountable to MOH who in turn reports to the BOH. To be eligible for MOH or an Associate MOH (AMOH) under section 64 of the Act, the person must be a physician, possess the qualifications and requirements prescribed by the regulations for the position, and their

appointment must be approved by the Provincial Minister of Health. Duties and responsibilities of the medical officer of health are stipulated in section 67 of the Act.

The MOH reports to the BOH on issues relating to public health concerns and public health programs and services as stipulated under the Act. Roles and responsibilities of the AMOH are stipulated in section 68 of the Act. The AMOH assists the MOH to perform duties as may be delegated by MOH and have full powers of the MOH. It is important to emphasize here that section 70 of the Act entitles the MOH of a BOH to notify and attend each meeting of the board and every committee of the board. Section 70 is important because it creates a site of analysis for mediation, contestation, and subordination or advancement of HE/SDH concepts at the municipal scenes of decision-making. Thus, for this section, the HPPA as an organizing text, is relevant as far as organizing the structure of public health. In the next section, I turn to analyze the Ontario Public Health Standards.

6.9.4 The Ontario Public Health Standards (OPHS)

The OPHS is the text-based instrument for the social organizing of public health activities in Ontario. It is released every three years and defines the social relations as well as the social organization of public health service delivery across the province. In IE the "material and reflexive coordination of people's actions, as observable and reproducible across time and place, constitute the social organization of people's experience." (Bisaillon, 2012. p. 618).

IE understands the social world as arising in people's everyday activities that are coordinated through social relations beyond an individual's local experiences (D.E. Smith, 2005, 2006; Winton, 2019). In other words, the work that people do socially at one location may be organized from sites far away and transmitted through texts. Often these everyday activities are

organized against the interests of those affected, who may not even be aware of how their activities are organized (Rankin, 2017; D.E. Smith 2006).

Thus, the OPHS defines the work that public health does, directs on standards of accountability, and sets the public health indicator framework for program outcomes. The three parts of the OPHS describe the protocols which provide direction on how boards of health should operationalize specific requirement(s) of the Standard. The aim is to ensure a unified operationalization of the requirements across the 34 boards of health. The OPHS has guidelines that provide direction on how the boards of health shall approach specific requirement(s) of the Standard to achieve consistency across programs and services across health units based on local contextual factors.

The Standards also contain references to topic-specific documents that provide information (Ontario Ministry of Health and Long-Term Care, 2021). The most current OPHS is a 79 paged document that became effective June 2021, and it is entitled: *Ontario Public Health Standards: Requirements for Programs, Services, and Accountability – Protecting and Promoting the Health of Ontarians.* Each BOH ensures that its health unit is adhering to the Standards and therefore the MOH for each board reports directly to the Board of Health as already described. In the preceding section, we look at the social organizing of public health and the approach to HE.

6.10 Conceptualization of HE/SDH in the OPHS

In its chapter 1 under the Policy and Legislative context of public health, the OPHS clarifies what it means by public health, and its focus. It states, "The focus of Public health is on the whole population" (p.6). It further describes public health using the following achievements:

> "Public health interventions have made the food we eat safer, 'they have protected us from infectious diseases' and environmental threats to health, and they have created healthier environments to support and 'inform choices about risks,' including those related to tobacco and alcohol. Public health also impacts communities by 'developing healthier built environments', responding to public health emergencies, and 'promoting social conditions' that improve health." (p.6).

The quoted texts above affirm the individualist thinking that informs biomedical approaches to public health which focuses narrowly on individual choices and risky behaviours; the subsequent quote illuminate the traditional conceptualization of public health – protection and prevention. The last quote affirms the extent of upstream that a progressive public health system could reach. The Standards further elaborates how public health should work as follows:

> Public health "works through multiple channels and on multiple issues" to have an impact on the "health of the population". The work is diverse, including individual clinical service delivery, education, inspection, surveillance, and 'policy development', among other activities. What unifies public health action is its focus on prevention, 'upstream' interventions, and 'societal factors that influence' health." (OPHS, p.6).

In the above extract, we see that stakeholder participation is recognized as legitimate in public health work and it should be. That public health addresses multiple issues with a focus on population health. Of the services that public health offers, policy development as well as the upstream approaches and social factors are recognized, albeit casually.

The purpose of the foregone analysis is to demonstrate a problematic in IE. A problematic is when an institution may say one thing in its texts, documents, policies, or standards, and the institutional actors hooked onto work by the same texts of the institution may have different conflicting or contradicting everyday work experiences (D.E. Smith, 1987). In particular, I will show how the commitment to progressive public health may be at odds with practices in public health units due to constraints beyond what the actual worksites can comprehend. However, I will provide a deeper analysis of the OPHS. The Standard further elaborates on public health work as follows:

> "Public health work is grounded in a 'population health approach' – 'focused on upstream' efforts 'to promote health' and prevent diseases to improve the health of populations and the 'differences in health among and between groups'. Health risks and priorities change as people grow and age and public health work to address health across the life course." (p.6)

The above extract demonstrates a dominant narrative in health promotion. There may, however, be a conflict between promoting a population health approach and pursuing an upstream agenda. In Canada, the debate over population health as an emerging paradigm in public health work raged in the 1990s and has still remains unresolved today. The focus on population health at

the provincial level is of interest as it is at loggerhead with, for instance, a more favourable phrase such as 'health-for- all people' in Ontario. Coburn (2003) argued that the rise of the 'population health' paradigm in Canada in the 1990s also coincided with the rise of a narrow approach to health promotion that reinvented biomedical hegemony and did not transcend it. Coburn (2003) writes:

> "…many population health analysts seem to believe they are producing a neutral and universally acceptable research and policy paradigm, whereas they are actually bringing forward a specific, narrow, and, we would argue, the asocial combination of epidemiology and economics." (p.393).

In the above quote, Coburn was short of stating explicitly that population health advocates had become allies of neoliberal politics. Beyond Coburn's critical appraisal of the notion of population health, Raphael and Bryant (2002) elucidated further that population health models are steeped in epidemiology and honors quantitative analyses while eschewing structural analyses of societal structures as determinants of health. Population health further elevates scientific social production of knowledge over health promotion concepts. The population health model has been criticized for providing powerful rhetoric for the retreat of the welfare state and thus a countervailing discourse on health and its determinants, and have a commitment to and faith in an ultimately biological explanation of health and illness, rely much on large data sets, lack a substantive theory of society and social change, pay little attention to the physical environment and lack human agency (Poland, Coburn, Robertson, & Eakin, 1998; Coburn et al., 2003b; Coburn & Poland, 1996; Raphael & Bryant, 2002; Robertson, 1998; Labonte, Polanyi, Muhajarine, et al.,, 2005). The province's bold approach through the OPHS on applying the population health

approach is an emphasis on the biomedical models of conceptualizing and operationalizing public health functions. This is similar to the social organization and conceptualization of health and health policy work at the federal level whose design aligned with the social-positivist approaches (Aggleton, 1990).

In the OPHS, the policy framework for public health programs and services section sets the goals, outcomes, domains, objectives, and programs and services. According to the policy framework, the goal of public health is to improve and protect the health and well-being of the population of Ontario and reduce health inequities. Three key population outcomes that are specific to HE/SDH concepts were identified as:

- Improving health and quality of life
- Reducing morbidity and premature mortality
- Reducing health inequity among population groups

The domains identified were SDH, health behaviours, healthy communities, and population health assessment. The objective under SDH is to reduce the negative impact of SDH that contributes to health inequities. When you examine the programs and services section, only one level may be attributed to addressing the HE/SDH concept directly, in the materialist political economy sense. That is, to reduce health inequities with an equity-focused public health practice. One of the principles of achieving SDH work that a public health unit is mandated to is to assess the distribution of SDH and health status. Beyond that, there are no concrete programs and services that address social determinants such as poverty, homelessness, poor and unaffordable housing, unemployment, guaranteed income strategies, and other socio-economic inequalities that affect the people of Ontario.

6.10.1 HE/SDH Concept in the Standards

While health promotion and policy development is identified as a core purpose and within the scope of the Standards, the boards of health are responsible for these programs and services in all core areas and are accountable to the ministry of health. The BOH is tasked to monitor and measure the effectiveness, impact, and success of these programs and services (The Standards, p. 11). What constitutes work for public health in Ontario is defined as:

- Population Health Assessment
- HE
- Effective Public Health Practices and includes:
    - Program planning, evaluation, and evidence-informed decision-making
    - Research, knowledge exchange, and communication
    - Quality and transparency
- Emergency Management.

The Standard further directs as follows:

> "The Program Standards is grouped thematically in the following areas; Chronic Disease Prevention and Well-Being; Food Safety; Healthy Environments; Healthy Growth and Development; Immunization; Infectious and Communicable Diseases Prevention and Control; Safe Water; School Health; and Substance Use and Injury Prevention. Boards of health [*are required*] to assess, plan, deliver, manage, and evaluate programs and services cohesively across these thematic areas, impacting multiple settings and meeting needs across the lifespan." (p. 16).

In the above extract, we do not see food security, healthy growth, and development, for instance, as addressed to SDH work to be done directly by PHUs. However, how food security is addressed varies across public health units. Toronto, for instance, had an independent food policy department which later became degraded and appropriated to social development and finances. The early childhood programs are varied and one of the most celebrated programs within Toronto Public Health. However, not all programs that address HE/SDH are directly aligned and communicated. Moreover, programs that should be universal are actually means-tested, like dental care, childcare subsidies, and others. Due to the silos, it is difficult to conduct the HE impact assessment from a public health perspective.

Furthermore, the OPHS recognizes that health is influenced by a broad range of factors, listing genetics, individual lifestyle and behaviours, and then the physical, social and economic environments in which people live. The recognition that socio-economic conditions impact health makes a strong case for work on HE/SDH.

Thus, the way the public health standard refers to SDH is not by designing programs or policies that address them directly, or through a concrete interdisciplinary or inter-departmental intervention. Rather, it gathers and analyzes data on family income, family education, immigration status, and so forth to identify disparities in health experiences. According to Raphael (2010)[30] the term HE is more deliberately, intentionally, and persistently used in Canada to conjure up the imperative for state actions to remediate the unjust differences in the population's health. The Standards then recommends that the population health data exposing disparities be used for targeted intervention for the identified "priority population" (p.21). Thus, the BOH is supported to

[30] Raphael, D (2010). HE in Canada. *Social Alternatives.* ***29***(2), 41.

endorse programs and services that are tailored to meet the needs of the priority population and to engage in policy work aimed at reducing barriers. In this light, we see that at both federal and provincial levels, HE/SDH targets a disadvantaged population. The standards state:

> "By assessing the social determinants of health, boards of health have a better understanding of the impact of various social constructs within their communities and are better able to plan programs and services that can help address health inequities."

One of the critics of population health was that the lifestyle approach always neglected the social, economic, and political context in which individual behavours are enacted (Robertson, 1998). As such, population health proponents end up blaming the victims, and not targeting a population. Either way, these approaches only lead to blaming the victim or making a targeted population appear as if they were failing because they lacked the knowledge to make appropriate lifestyle choices. This approach obscures the societal structures and the lack of power as determinants of health and therefore responds through patronizing programs that do not address the main challenge of unemployment, income inequality, poverty, and unaffordable housing, among others.

The OPHS mandate the BOH and community partners to implement strategies to reduce HE among the Indigenous population. It further recognizes that community partners and the public, are aware of local health inequities, their causes, and their impacts. The role of community partners and multisectoral collaborations in supporting actions to decrease health inequities is recognized. The Standards further direct that the voices of priority communities be included in the planning of public health interventions (OPHS, p.22-23). In short, HE is defined, discussed, and promoted in

the Ontario Public Health Standards and made visible textually. Being visible, however, is different from being activated or acted upon. There are various considerations such as the use of the population health approach that may be obscuring and undermining policymaking as work that could advance achieving HE/SDH policies beyond current expectations.

Although HE concepts appear to be well articulated in theory, in practice, it is often reduced to mean access. In a previous section, I elaborated on the consequences of reducing HE into 'gaining access' because that is only one part of equity. Equity without power, empowerment, and changes to societal structures that perpetuate inequities runs short of any good action intentions. Furthermore, when equity is applied to the marginalized and packaged as a risk-mitigating action for individual behaviors, then, as Robertson (1998) observed, such actions obscure the social, political, and economic contexts within which such behaviors occur.

6.11 Summary of this Chapter

I situated my institutional analysis at the provincial legislative scene to enumerate how policy considerations of HE/SDH concepts obtain across in three provinces. I focused on how certain groups interact with policymakers to advance HE and how policymaking is organized within the legislature to promote or resist the HE/SDH concepts in three provinces. I then turned my gaze to Ontario as a case study because it was more convenient to find data locally. I also understand the working of the public health system in Ontario better than in the other provinces. In Ontario, I identified two relevant texts that organize the institution of public health as scenes for advancing HE/SDH concepts in health policy and another text that defines public health standards in Ontario. I described the regulatory and also the structures that socially organize the work on HE/SDH concepts specifically in Ontario. The Health Protection and Promotions Act,

1990 (HPPA) was analyzed as the boss texts. The activation of its clauses directs the Provincial Chief Medical Officer of Health to produce a subordinate text, Ontario Public Health Standards (OPHS). The two are the most important and relevant texts for this study.

The OPHS guides the delivery of public health services, interventions, and innovations for three years. I provided insights into how health equity and social determinants of health are conceptualized in these texts and activities if advancing these concepts at institutional sites. In analyzing the relations of ruling arising from the highest-level texts, I attempted to make visible how Ontario Province makes the role of corporations or corporate voices explicit or prominent in policy discourses. The corporate/business influences stretch to the various policymaking scenes more glaringly compared to corporate voices at the federal government level institutions. For instance, the HPPA gives the Lieutenant Governor in council sweeping powers to make many critical regulatory decisions that may affect the prioritization of public health work. In section 96 (1) (e) the Lieutenant Governor in council can exempt any person, organization, and private sector players from any provision of the Act. (This may be happening at the federal level too, but I did not find it to be as explicit as it is at the provincial level). The role of the Lieutenant Governor in council as captured in section (e) below may elucidate my argument:

> (e) exempting any person, organization, premises, food, substance, thing, plant, animal other than man, solid, liquid, gas, heat, radiation or combination of any of them, or any class of any of them from any provision of this Act or the regulations and prescribing conditions that shall apply in respect of any such exemption. R.S.O. 1990, c. H.7, s. 96 (1); 2001, c. 30, s. 2; 2006, c. 26, s. 15 (2).

For a government that may be steeped in market-oriented development, corporations may escape scrutiny or act with much impunity with the above mandate afforded to the Lieutenant Governor at council. Of course, there is an expectation that the Lieutenant Governor will receive sufficient advice from experts before activating these clauses, but this is not explicitly stated. Nonetheless, what constitutes advice and scientific evidence in a corporatized environment needs to be properly scrutinized.

The OPHS, on the other hand, is the text that socially organizes work on public health services and policies in the province. I showed that the focus of the OPHS is mainly on promoting the traditional roles of public health steeped in the biomedical models or biological explanations of health and illness and therefore, responding through clinical and/or diseases-oriented approaches.

This approach is buttressed in the Standard's focus on a much-critiqued market-oriented biomedical population health as a paradigm of practice, I acknowledged that Ontario public health programs offer some of the most generous and yet means-tested services such as early childhood development, universal dental services for children under the age of 18 and older adults and seniors, and so forth; however, these programs target certain population similar to federal trends. I showed that HE is visible in the OPHS and the obligation to implement programs to mitigate inequities in society is heaped in the mandate of the boards of health. Interestingly, members of the Board of Health are often not well oriented to the HE/SDH concepts and some resist it. Through textual analysis, I showed that HE as presented in the OPHS is reduced to 'access' to knowledge and services for a targeted disadvantaged population and this is the same as federal level approaches. In its totality, this aspect of the social organization of public health in Ontario is like that at the federal level. Furthermore, at the provincial levels, the role of civil society and labour

unions in influencing HE policy is limited and the current Conservative dispensation has been found hostile to the concept of HE.

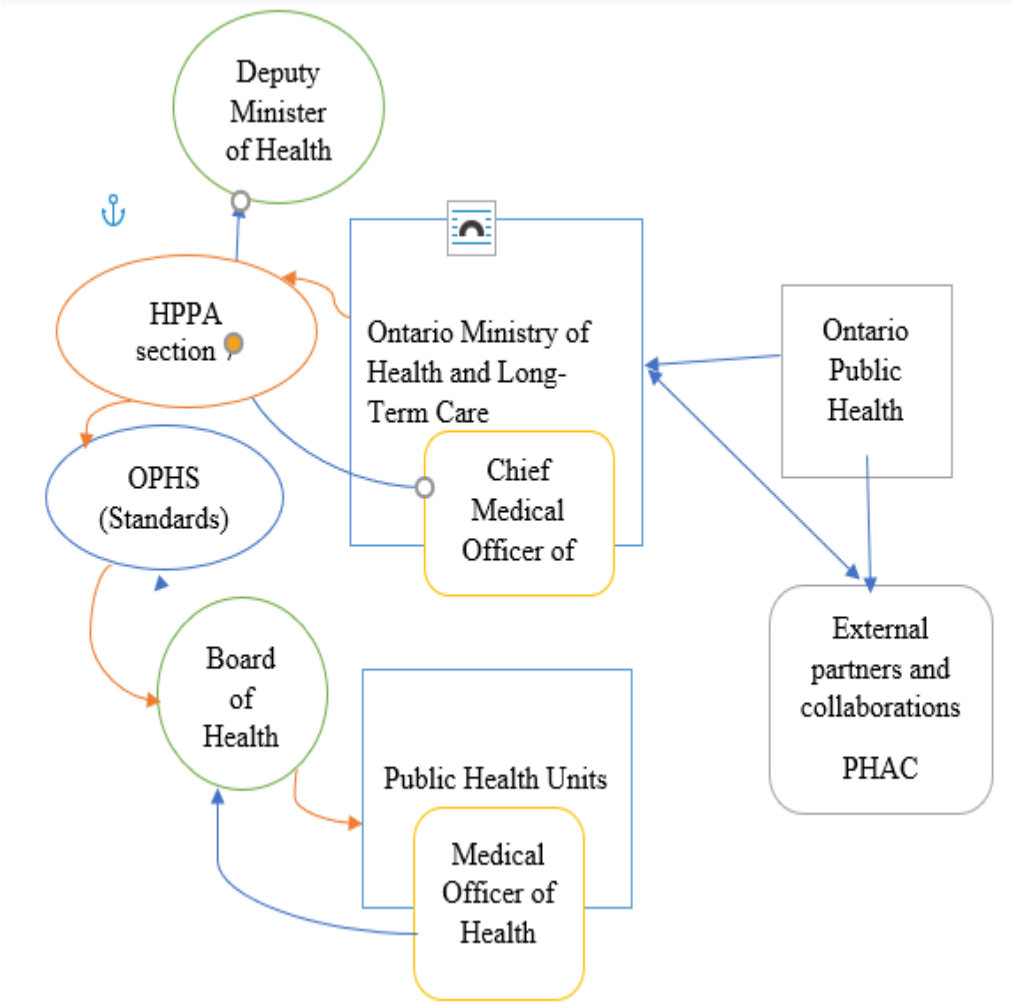
In the next chapter, I explore from the standpoint of policymakers at the municipal level, how the Standards are translated into concrete actions on HE/SDH policies. My argument here is that real public health actions that impact everyday people's lived actualities happen at the municipal level and therefore, we should expect more concrete policy undertakings on health equity in actions at the municipal level.

Chapter 7: Public Health in Practice: Municipal Level

This chapter is about the social organization of public health services at the municipal level. Public health units have the most immediate mandate to attend to HE/SDH concepts to ensure that

public health interventions are reaching communities. The goal of my analysis was to reveal how HE/SDH are conceptualized, negotiated, promoted, and/or subverted/resisted within municipal government-level institutions of health policymaking. This section speaks to three levels of policymaking and decision-making based on the social organization of policymaking as work: The Board of Health (BOH), Senior Management Teams (SMT) of public health units; and Public Health Policy Specialists (PHPS). Below I summarize the structure that represents how public health is organized in Ontario.

Figure 6. 1Textual coordination of public health in Ontario



7.1 The Municipal Board of Health (BOH)

BOHs are constituted by elected Municipal Councillors, appointed civil servants, and citizens' representatives as earlier described in the HPPA. Since the provincial documents that socially organize public health get activated and operationalized at the peripheries, i.e., at the BOH and local Public Health Unit (PHU) sites, the standpoint participants of interest are also selected from policymakers from these sites of activation of the texts. BOH is constituted in the same way for urban and rural PHUs.

The standpoint participants demonstrated that the structuring of the BOH may be constrained in its decision-making because of the nature of the technical issues it has to make decisions on. The constraint is partly owing to most of its members being elected representatives, with some having no background in health, HE, SDH, public health, or epidemiology – or even interest in these issues especially if they are from an affluent neighborhood.

Accordingly, the BOH is set up in a paternalistic way; public health experts produce reports in consultation with stakeholders, and most of the BOH may have little idea of what the reports are about or their implications for their electorates. According to the standpoint participants, the AMOH Technical Reports that appear before the BOH have to be sanitized of professional language and tailored to represent the views of public health professionals in a simple plain manner. In other words, the arrangement of the BOH is such that it is subjected to the knowledge, practices, and traditions as socially reproduced by public health to which board members must debate or approve even when they understand little. Standpoint participants elaborated the work experience as follows:

> "The Board of Health, which is obviously constituted with civic appointments and people who are subject experts or perhaps they are designated because they are a school trustee."

> "The BOH is set up in a very paternalistic way already, so therefore there are the experts which are public health staff, they produce a report based on research and conversations with stakeholders."

> "MOH report goes through a sanitization lens to make sure its language is somewhat accessible, but they also choose and determine what gets inputted into the report, and what their recommendations are, and oftentimes there's not a budgetary tie in."

The above quotation highlights the power structure and how the scene at BOH meetings can both evoke tension and ameliorate it simultaneously. However, under these circumstances, conflict can easily form between the contest of evidence and the politics of the day. The standpoint participants acknowledged that board meetings are potential scenes of such conflict but often end up being a place of balance of power, to leverage the paternalistic set-up between BOH members and PHU officials. In such a scene of power struggles, the balancing act is determined by the BOH member's budgetary vote rights. While the expert flouts their knowledge and use evidence that may inundate the BOH members, the BOH finds their voices to demand clarity and accountability by using the budget as a tool of choice.

However, the boards hold the power to evaluate and approve PHU programs, any health policy undertakings, services, and ultimately, approve funding. Thus, in situations where tension may arise, the standpoint participants testified that the board could use its powers to withhold the

operating budget of the Public Health Unit for a particular area of concern until clarification is made. For a PHU to get their budget approved for programs, policy, and innovations, they must ensure that the highly technical reports they provide are accessible, and its implications understood by board members, especially those who hold budgetary voting rights. If those members do not understand and are not satisfied that a Public Health Unit is meeting its objectives, then the BOH may vote against the budget. The standpoint participants summarized their experiences as follows:

> "But we all know that the budget is the apex of every single policy tool of government, without a budget allocation, every strategy every plan and it just, it just does not get operationalized."

> "We recognize that it's not necessarily the fault of anyone who's working in the Board or the Health Unit. It is just the system that we are in the structure that we are working in. So, already we know where we're not going to get into the deep dive unless you happen to perhaps be the researcher who's cranking out the report, who's turning all that information and quantifying and try and make sense."

In the above quotation, the standpoint participants identified the systemic challenges owing to the institutional architecture in which the boards operate as restrictive, repressive, and constraining. Moreover, such arrangements do not facilitate dialogue between the public health professionals and the board members. As a result, board members have had to do due diligence by requesting public health professionals to provide accountability and some form of feedback that their technical recommendations demonstrate adhering to the Ontario Public Health Standards. This demand for accountability is linked to the population and stakeholders' expectations of the

municipal government's actions on SDH. Below is how one BOH member expressed frustration with PHU's technical reports.

> "And I know city staff writes the report like that all the time. What can they get away with? So, already, it's set up in a way that the content coming to us is going to probably be simplified. Right! And then we have this environment where you know we have five minutes to ask questions of a probably a simplified process for us because they want us, they want to simplify things but as they get down, interesting as they get to the top decision makers, they simplify it more and more for us."

> "We may ask some questions. When there isn't or there is that there is a response from staff and usually it's a very credible response. And we will generally either amend the report or will be adopted as is."

> "But the feedback loop around accountability and transparency disappears after that, in my opinion, not entirely. But oftentimes if we don't ask for measured outcomes, to understand whether or not we have, as you know tackled, the issue around gun violence. I don't think it is going to be very effective."

The above statements are reflective of the dilemma in the relationship between BOH and PHUs. The PHU work is text-producing activity (reports) whose technical reporting has to be watered down to augment accountability. As such, standpoint participants feel that much of the content of the report is lost in the process of watering down the technical language to make it accessible. This is problematic in that the standpoint participant struggles with making technical

reports and accessible language at the expense of diluting the available supportive evidence highlighting the depth of policy work on HE/SDH. The standpoint participant describes how technical reports from her department get simplified for policymakers at the BOH. Such reports hardly clarify what constitutes health equity and actions on SDH in the concrete term. Instead, health unit staff use vague or ambiguous language to evade scrutiny at the Board of Health where they may fall short of convincing evidence. Another potential source of conflict is that some Board of Health members do not believe in some of the public health measures on SDH through HE tailored policies, programs, and innovations. To win them over, PHU leaders have to use multiple strategies to explain the same concept.

The lack of aggregated data was seen as an area that PHUs have to improve to enhance the communication of how policies tailored to health equity are directing actions on SDH to improve the health of all Canadians. Standpoint participants identified a lack of aggregated data where public health units fail to demonstrate the effectiveness of their programs in respect to HE/SDH concepts. Here are how three standpoint participants articulated their experiences:

> "The problem with the way our government is set up, and I think every order of government has the same problem, is that how do you measure the eradication of poverty if you're not collecting disaggregated data at the beginning at the implementation stage, and at the outcome stage. This health unit is horrible at collecting disaggregated data."

> "So, we may be able to collect some numbers, for example, 81,000 people could be on the waitlist for some form of subsidized housing. Well, that's great. You have one measurement, one-unit measurement. Now we need to think and take a little deeper, how many of those

people are women. How many of those people are racialized how many of those people have been on the waitlist for this many years and so forth and so forth that we need to be able to break that down further."

"When we are able to do that (collect disaggregated data), intelligently and honestly, we will then have a much clearer picture of who are we leaving behind in the [community], based on the policies and the programs and services that come out of the policy direction. How have we delivered it effectively?"

The quotes above revealed yet another critical area where standpoint participants believed could help drive the dialogue between BOH and PHU on HE/SDH concepts if the PHU gathered and used disaggregated data often. Despite the need for disaggregated data, only a few policymakers at this level were even able to identify the lack of robust data as hindering work on HE/SDH in the policy. The provinces and PHU collect a variety of data that are readily available and accessible for those with a legitimate interest in studying them. Besides, the HPPA mandates the board to ensure that such important data is collected and reported regularly, especially among the underrepresented population. If the appropriate data collection is not happening, then the board has the mandate to request that PHU begin gathering such data to allow for a deeper understanding of the extent of social and health inequities in the communities.

7.2 How Policymaking as is Socially Organized at the BOH

The standpoint participants reflected that Canadian cities are organized as corporate entities. Therefore, it is not surprising that city services are organized as 'for-fee-services' to emphasize

the cost-sharing element of the market economy. The BOH members who are councillors attest that they are elected not to form a government, rather to sit on boards of corporate municipal entities or cities. This experience may be different from the experiences of the BOH that oversee public health units in rural communities. The larger cities are managed like corporations. The elected councillor has to cut their teeth as a corporate board member and a community advocate. The role of Councillors as corporate board members is contradictory in many ways to the role we would expect then to play in promoting equity. W shall see later how this corporatization of legislature affect health equity policymaking when we explore external influences on the BOH. In describing their role, e standpoint participants had the following to say:

> "When I am in City Council, there are two things that I do. There is a view of councillors as a member of the board of directors of a corporation, we are in fact, a corporation city and not a government. They're [cities] actually corporations. You're on the, you get elected to be on the board of that Corporation."

> "If you're on this side, like being conscious not a bad job, right, the board of directors, got the suit, looking cool, make the decisions, raise your hands, you're, you get to hang out with the dudes that make the news"

> "This other side [community] and you're hanging out with the dudes that never get in the news, or rarely get the news, or if they're in the news, not for good reasons. But that's the work that's the good work. And one of the things I learned, especially in Peru, Indigenous culture community, strong community values, right"

In the quotes above, the standpoint participants recognize the conflict inherent in the duality of being a councillor and being a board of directors of a city as a corporate entity. The standpoint participant recognizes that being a councillor requires one to be conscious of their privileges – as a corporate actor and as a community activist. These two roles are not exactly reinforcing, rather, they are often antagonistic when addressing HE. As we shall discuss later, the corporatization of the cities makes it hard for HE and SDH concepts to filter through health policy because of a potential concern over conflict of interest. Precisely, redistribution of wealth hurts business/corporate profit interest and disrupts the accumulation of wealth typical in the corporate world, therefore redistribution is often resisted. The conflict disjuncture that policymakers experience in their dual roles may be different for BOHs for the urban and rural public health units and may require further inquiry.

7.3 Institutional Conceptualization of HE in Health Policy

In this section, I focus attention on the concept of HE in health policy. My goal is to explore from the standpoint of policymakers how they discuss, negotiate, advance, or subordinate this concept while deliberating at the BOH meetings.

7.3.1 Equity, a Widely-Pursued Goal of Public Policy as 'Access' to Services

The BOH, like the other levels of government, usually believes in pursuing HE as a noble goal of policy to act on SDH. In this regard, some policymakers at the BOH, conceive HE as providing 'access' to services. Here is what one standpoint participant stated:

> "We're here to represent the people and we need to develop good policies, laws, and bylaws to ensure that people can have access to opportunities to develop a way of life that is fair."

> "If we actually have some type of equitable access to housing. Everybody will have a roof over their heads."

However, another standpoint participant who may understand the full scope of health equity and how it plays out, challenges the idea of reducing equity to access and thereby making HE an issue of access to health care services. This is how they elaborated:

> "Of course, they were. It was about. It was about who had the recreation programs, who had the library card, who got its post-secondary education, what kind of job. What was the pay for your job? What was the support you had when you know we all do stupid things in our life? Look at the differential treatment based on race before the police. I had support from teachers. When you had a run-in with the police, how did you get off"

In the above quote, the standpoint participant is stating that some people have privileges that go beyond access to services. For instance, how do they escape arrest or a run-in with the police while members from other racialized groups face racism at service points, for instance, may get arrested and violated for being mere suspects?

While some standpoint participants narrowly understood HE as making 'access' to health resources available to people, there are policymakers at the BOH who displayed a complete understanding of HE, and this is how one of them articulated:

> "Let me say you are a smoker; I was very active on the non-smoking campaigns. I can get you to not smoke. We put in place a whole bunch of policies around the sale of tobacco, or on the pricing of tobacco-run advertising around their ability to use movies and networks to make it the easiest way possible. So, whether you're rich or poor, doesn't matter what side of town you come from, you have the availability of good health, by virtue of containing the influence of big tobacco."

> "If a parent can get home in time, and we know lots of people working shifts these days, so that young person isn't left on their own. So, we need to step in and fill that gap. We need to provide some programming that's going to allow the youth to be themselves, because they're still figuring life out, right, so you're a teenager, you're like, I don't know what to do. So, we need to construct, those services to meet people where they are."

While members of the BOH believe that HE is necessary for public policy to reduce health inequities, most of them think of equity in the form of access to services like libraries, a health center, a swimming pool, etc., and it ends there. This, as we have articulated before, undermines the other tenets of HE such as the imperative to act to narrow the gap (Graham, 2004). Some BOH members, however, have a good grasp of HE and do understand that equity is not just about removing barriers; it also entails addressing systemic challenges and where possible, initiating a

system's change that focuses on narrowing the gap between different groups in a society. For instance, narrowing the gap between the rich and the poor, by enacting HE policies to redistribute social and economic resources fairly.

7.3.2 HE as Activist Language that is Galvanizing and Polarizing

The Eleventh Edition of the Merriam-Webster Collegiate Dictionary (2007) defines galvanize as "to stimulate or excite as if by an electric shock" (p.513). The same dictionary defines polarize as "to break up into opposing sides or factions" (p.959). When the two terms are applied to a public health issue such as HE/SDH, it depicts a scene where every actor appears simultaneously excited about and polarised by these concepts. Some of the BOH members consider HE galvanizing because it gets everyone listening with zeal. Such discussions may also be very polarizing in other sociopolitical settings. After all, it gets everyone questioning what actions need to be taken. This is how the standpoint participant summarised their conceptions:

> "Yeah, the words, social, and justice seem to be extremely galvanizing. I find this to be the case in the building that we sit in today at City Hall, this is the civic seat of government."

Another standpoint participant observed, thus:

> "The word social justice is galvanizing, and it's polarizing, but at the same time I think that if we don't name it properly, we're not going to get to the root causes and, ultimately, the good outcomes that will benefit everybody, including the ones that built the system."

The quotes above reveal how strongly some BOH members think and understand HE or think and reject these concepts altogether. This may also explain their lack of action in ensuring that HE concepts actually filter into health policy recommendations and government takes swift action on SDH. When it comes to social justice discussion, the BOH members experience polarity on grounds that some Board members think that social justice is an activist language, and they immediately see placards flying around. One standpoint participant had this to say:

> "If you say the words, social housing, as opposed to perhaps, affordable housing. Right! And if you put the word social in front of justice. It now contours to the mind, people who are waving placards who are, you know, shouting out slogans outside the government building."

The above quotation captures the challenge of promoting HE among the BOH members because these HE/SDH concepts are the popular policy goal in a country where inequities are commonplace. However, the polarization effect when social justice is brought into the picture, means that either some of the board members do not fully know the concept, or they simply do not want to advance it. There is a group of policymakers who are conveniently afraid of demands for social housing, or being considered an activist or universalist scheme for free housing. This group may prefer to pursue affordable housing schemes – a language steeped in neoliberal market policies

7.3.3 HE as Subversive to Status Quo

One of the concerns of standpoint participants is that the demand for HE can be seen as subversive to the status quo. It threatens the privileges and powers of the status quo and may not be tolerated. One standpoint participant said:

> "I think that that is seen as oftentimes a threat to the institution, the structures of power. And what oppose those structures of power or those who are benefiting from those structures of power, and they're oftentimes again."

Another standpoint participant, when asked about the origins and pervasiveness of the status quo, said the following:

> "People who are of European background, oftentimes heterosexual males who are oftentimes already benefitting tremendously – benefiting from wealth from social currency, from the sort of the affluence. And so, for them, the system is working perfectly well. It doesn't need to change, because the system was designed by them for themselves. So, it works for them."

From the above quotation, HE, when used in the context of redistribution of cultural, social, economic, and political resources, tends to irritate a certain social base who may consider such actions an affront to their established patterns of privileges. These are people, who are established through a mixed bag of history of hard work, exploitation, and privileges, derived from their race and history of being a European.

7.3.4 Equity Pursuit as a Justifiable Cause

While some standpoint participants viewed the pursuit of HE suspiciously, some policymakers believed that the pursuit of HE in Canada today was justified. They felt that the system of governance or the welfare system, in the case of Canada, does not work for nearly 90% of the population. The standpoint participants demonstrated that Canadians are working two or three jobs, more often single parents, and taking long train rides between jobs. The standpoint participant had the following to say:

> "Unfortunately, the system does not work for the 90%, who are outside the building, who are looking in and trying to understand why they are going to bed hungry. Why are their children being tempted to move into gang recruitment?"

Another standpoint participant elaborated their experiences as follows:

> "The lifespan of a sub-Canadian group was 54 years old, of the poor, the poor half. In the other richer half, the average lifespan is 85-90 years. Right, so it. We say it so often that poverty will make you sick, and guess, right, poverty will make you sick. But then, you know, the people who are on the other side, who think individualistic say no you have the right to a doctor as much as I did."

In the above quotations, the standpoint participants identified inequities that result from the structures of society, not individual's innate abilities to make bad choices that affect health as emphasized in the OPHS or the dominant individualistic/biomedical discourses. Generally, a poor health condition reflects people's actual living conditions and corroborates the context in which

behaviour occurs and recurs. It, therefore, justifies the imperative to pursue HE as opposed to taking statistics of disparities which is the conventional approach of health policy experts to avoid the moral imperative attached to HE policy for action on SDH.

7.4 Institutional Conceptualization of SDH

In the last section we saw that within the BOH, the conditions are skewed against the promotion of HE. First, at the municipal levels, elected leaders are usually sent to sit on corporate boards since cities are managed as corporate entities. Second, several board members resist HE on the account that it is an activist language with a galvanizing and polarizing effect on policymakers and society. HE is also resisted on the ground that it challenges privileges and powers of the status quo. Despite all of the above, some board members do understand the imperatives of pursuing HE and recognize the inherent needs for equity-driven public policy. Their concern is that the welfare system is not working for most Canadians. In this section, I present findings of the conceptualization of SDH at the BOH level. The theme that emerged is that standpoint participants at the BOH did not believe that PHU was doing enough to promote SDH concepts in action.

The standpoint participants at the BOH view the role of PHU differently when it comes to promoting SDH concepts. The standpoint participants believe that public health was, itself, least interested in advancing SDH or doing anything robust about SDH. Some standpoint participants questioned the legitimacy of modern public health as the driving force to cause a system's change. The following three quotations summarise the experiences of the standpoint participants:

> "Yes, there's something wrong with the system. So, it's just me thinking and that's really what public policy, especially public health policy is really about. It's about systems thinking. What are the systems that push people to the margins? What are the systems that

keep people in positions of power and privilege in what? In the fact that, that this gap is growing."

Another standpoint participant observed their disenchantment with public health for its failure to address systemic inequities as follows:

"That system should be visible but not everybody sees it though. Not everyone. Even people of goodwill don't see it and there's a reason that I'm sure you'll ask me sooner or later."

When probed further to elucidate the above perception about public health, the standpoint participant elaborated like this:

"Well, not in the public health world have I seen system changes. I don't think there have been big changes. Because I think frankly, public health people by their very nature and by the very nature of their business, the work that they do tend to be systemic thinkers and systemic actors."

In the above quotes, the standpoint participants demonstrated that public health units, under the current neoliberal or political arrangement, are incapable of igniting and leading systemic to narrow the gap in the socio-economic gradient in which health resources are significantly allocated and redistributed through equity public policies.

7.5 Institutional Conceptualization of HE/SDH Work as Divisive

This section depicts what policymakers said they experience when talking about HE and SDH together as a reinforcing concept. It is, however, different, when they talk about HE and SDH as separate concepts. The standpoint participants at the BOH corroborate that at their BOH meetings, whenever the concept of equity or HE comes up in the context of SDH, the discussions become divisive. It sharply divides the BOH and sends some members into a retreat of deliberate silence. The standpoint participants reflected on their work experiences and said that in their discussions, they find that HE and SDH concepts are too loaded, and not every board member may be ready to engage in those discussions. The board comprises of elected representatives, some from equity-seeking communities and others from affluent communities. Board members from the affluent electors tend to escape or avoid indulging in HE/SDH discussions. The standpoint participant observed that it is partly because the affluent see no need for tolerating HE/SDH. After all, their communities are not impacted. In fact, the representatives of the affluent consider such discussion involving HE policy for actions on SDH as a threat to the base of their affluence – influence and power. The two quotations below summarize this experience quite well:

> "If we can focus on values and those outcomes in HE/SDH; if that's the "safe space", then I'm willing to work towards that. But I also don't want to eradicate the language [HE/SDH] because I've now learned that sometimes the language is so powerful, and also so prohibitive. There are people there ready such that their walls of resistance go up the steps with the discussion on HE/SDH."

> "If we start with a value proposition and say, "Do you believe that you know people who have dark skin should have the same opportunities that people with white skin have?" "Oh, yes! Of course! Absolutely!" "Is racism the bad thing?" "Oh, yes of course absolutely" is the answer. So, let's fix it. But if fixing it runs against the established norm or about calibration of the standard of the privileged here, then that becomes a problem."

The above quotations reveal that some BOH members are aware of the extent of the pervasive health inequities and recognize those who endure socio-economic inequities the most. However, when it comes to fixing the problem, they also understand well that it may require sharing in the privileges of long-established and dominant groups. Thus, the intolerance to HE debates and the particular avoidance of discussions on SDH concept is not so much about the lack of knowing what to do, rather, it is resisting to do what needs to be done. It is a display of systemic power and privileges that are socially and historically entrenched in society.

7.6 Institutional Influence over Health Policymakers' Work Experience

This section is about the institutional character – how institutional values, attitudes, traditions, and practices influence health policymakers and their experiences of working on HE and SDH concepts.

7.6.1 The Decline in Community Consultation

The policymakers at the BOH have concerned themselves with the decline in community engagement and the fading influence of public health in communities. The standpoint participants at the BOH corroborated that they do not hear community voices in public health's policy

recommendations. The lack of community voices signifies a decline in community consultation, and it works against HE policy on actions on SDH. The standpoint participant provided an example where the BOH was concerned over gun violence, community crimes and the increasing theory of left behind that they encounter during their own community visits. This particular work experience is common in urban communities such as in Toronto, Vancouver, Saskatoon, and others. The standpoint participant elaborated on the left-behind theory as cries from parents and young women left in grieve and caring for their children through generations as their sons or husbands get killed or jailed and subsequently locked-up in the criminal justice system. This is how the standpoint participant explained the experience.

Interviewer: Tell me more about your work experiences in the community and this left-behind theory.

Standpoint Participant: The one thing that the community members have asked for especially, the moms and the sisters who are kind of, you know, the boys get in trouble and then they either get killed, or they get caught and they go to jail.

Interviewer: And how does that play out?

Standpoint Participant: "And then they go they get turned out of this criminal justice system, and it's hard to recognize what happens afterward, but those left behind are the moms who are trying to deal with their grieving siblings and their grieving for their children.

Interviewer: And that has left a huge gap in the communities that deter upward mobility out of poverty.

Standpoint Participant: And, then oftentimes the girls were like, what do I do because now I'm like without my brother, fathers… so there's this whole left behind theory here, and what they have been asking for as well and I heard it loud and clear. I cannot imagine that the city powers here don't know, the community asked for counseling, what is public health doing about that?

This standpoint participants demonstrate a socially acquired knowledge from a standpoint of bereaved mothers, wives and children in a particular community affected by gun violence and crime. They see systemic and social issues that are part of the determinants of health yet do not commonly appear on BOH agendas because the voices of those affected are excluded from the narratives. Note that by the time of this study, intimate partner violence, drug overdose, and homelessness had surpassed gun violence in the community as a priority of major public health units.

The standpoint participants acknowledge that the loss of interest in community issues such as gun violence and crime has significantly eroded the community's political voice. The lack of a political voice means that it gets harder to secure the momentum needed to drive for a change in the system. This is how the standpoint participants captured their frustration:

"I feel like our priorities and how we think through what we do is, is upside down. And that's because we're still working with the master's tools. And so, how do you actually change that?"

By stating "…still working with a master's tool", the standpoint participant is referring to the hegemony of the dominant systems that shape the relations of ruling in society – the very system that produces, reproduces and protects the status quo, earlier alluded to. Another standpoint participant expounded on the systemic disadvantages that has become difficult for public health to fix as follows:

> "If the system that's created is working exactly the way it's supposed to. And the fixing tools that you get to change the system are the same tools that are set up by the system. So, I have struggled with this personally. It's something that I really take issue with."

The above quotations highlight the standpoint participant's frustration with public health systems as a whole for its failure to tackle HE policy to reduce social and health inequities in society. When standpoint participant stated "it is the system that created the tool", policymakers are expressing their work experience that modern public health is aligned to the hegemonic social and economic systems that are designed to erode the integrity of the welfare state system. Thus, for them, public health alone cannot be entrusted with the insurmountable task of chipping pieces of power and privileges from the grip of those entrenched in it, i.e., 'status quo'. The standpoint participants at the BOH acknowledged that the solution to health inequities is system's change. The decline in community involvement in HE/SDH policy discussion, however, denies the social change movement and the requisite political voices necessary for the desired change. In many cases, those in positions of power and privileges resist prospects for change of the status quo.

7.6.2 Institutional Racism

The standpoint participants at the BOH level, recognized institutional racism as one of the influences within their realms of policymaking. There is also understanding that equity-seeking areas tend to be for newcomer immigrants or people of color and, as a result of institutional racism, motivation for responding among many board members is low. The standpoint participants felt that institutional racism tended to limit the potential of Canada's multiculturalism ethos and undermine equitable investment in human resources and skills at all levels of government. This quotation summarizes this concern quite well:

> "Which is why I think it's always important to go back to the original valid value statement. Like if there are, for example, people who just deeply believe that racialized people are always going to be immigrants and considered as immigrants and outsiders that only one true race is the chosen race. I got it. And there are those who believe in that sort of very racist, ethno-cultural setup. Then we are not going to or they're not going to come to the same values that we will uplift the ones in need."

The above quote exemplifies the danger of extremist and in particular when racism becomes the defining character of public institutions, the dialogue on a fair society becomes futile. Another standpoint participant decried the pervasiveness of institutional racism and its negative impact on development of municipalities and national human resource base for Canada to be globally competitive, as follow:

> "If Canada is going to be a truly, you know, globally competitive nation. Then, in order for us to achieve what I think is potential for us, then we will need to understand how to break down the regionalism that the tribalism that sometimes exists in sometimes cities."

The two quotes above highlight the pervasiveness of institutional racism and its negative impact on Canada's human resource potential if certain groups are undervalued. It further underscores the potential for a missed opportunity in harnessing diversity for a globally competitive Canada. Institutional racism remains an issue at the BOH as an institutional site for policy decision-making for the promotion of HE/SDH concepts. If the Boards of Health are subtly prejudiced against a certain population or region, certainly, their policy actions will not favor such a group or develop their localities. This may partly explain the persistence of racism across public services and especially with law enforcement and employment of people of color at higher ranks of government agencies and parastatals.

7.6.3 Persistence of Individualism in Policy Discourses

The standpoint participant corroborated work experiences of having to content with the rise of individualist thinkers within the institution where they work. Standpoint participants observed that individualistic thinkers tend to dominate budgetary discussions or analyzing the impact of taxes on the population. The policymakers recollected that certain BOH members who represent the wealthy always favoured the tax systems that favours lower taxes for businesses and the wealthy. The standpoint participant's summary below explains it all:

> "That tax is a common good. And I got so many people, it's rare that I find 50% of a class or a group saying that they like paying taxes. It's rare now. That to me is the basis of individualism."

Another standpoint participant captured the essence of individualism as experienced at their work location as follows:

> "Individualism persists and to me it is that idea that supports this notion of, 'we are individuals', 'we are competitive individuals.' We will pay for something together if it offers us a competitive advantage together, which means that it is good for us, so we'll build a road."

Another standpoint participant was more philosophical and stated his work experiences with individualism as follows:

> "So, the private ethic has now superseded the community ethic, on an ideological level and I think the material basis for that is, frankly, the on the unequal distribution of wealth."

The above quotations depict the standpoint participant's everyday work experiences where certain BOH members question the benefits of paying more taxes, and also the benefit of diverting their taxes to pay for programs to uplift the poor. It emerged that when policymakers at the BOH see no value in investing in troubled communities with issues such as violence or homelessness

they oppose such efforts because their affluent areas do not experience those particular problems. It is a kind of a tunnel thinking.

A standpoint participant narrated an experience when discussing the need to open more shelters for men in Toronto. There were two councillors opposed to investing in more shelters anywhere in the city. Since the standpoint participant knew the two opposing colleagues well, and winter was abounding with existing men's shelters filled to the seams, she drafted a proposal to locate these men's shelters in the neighborhoods where the two opposing councillors represent. Upon seeing the proposition, the opposing councillors were infuriated and had to negotiate with the standpoint participant to remove the proposed shelters from their neighborhood on the account that a shelter would attract homeless people to their affluent neighbourhood and lower their property value. As a concession, the opposing councillors agreed to vote for additional setting of a men's shelter anywhere else. That creative motivation is how funding for shelter for men came about.

7.6.4 Conservative Ideology

Another important institutional influencer is the dominant political ideology in the BOH and the council as a whole. In Toronto and Ontario, the Conservative-leaning groups dominate governance. As we saw before, the HE concept is not consistent with Conservative ideology. One of the standpoint participants demonstrated that right-wing people do not connect the role of public health with minimum wages, housing, casinos, addictions and so forth. The Conservative refuses to acknowledge that gambling is an addiction that drive people into poverty, drug use, suicide and crime. This mindset perpetuates silos in government departments such that public health is not

allowed to provide advice on the impact of the action of another department on health. These quotations succinctly summarize this point:

> "Yes, the right refuses to see that. They do not want to see that connection between public health and minimum income debate or housing. They don't want, here is a good example, Casinos. So, casinos are really a tool of the system to take more money from the poor and give it to nourish the rich. The reverse Robin Hood effect, giving you the illusion of the possibility of wealth."

Another standpoint participant explained the conflict between conservatism and HE/SDH concepts like this:

> "The Medical Officer of Health gave a report [Casinos] and as we work on it and looked at the scientific aspect, the impact on neighborhoods on individuals who have a gambling addiction and recommended some actions to the mayor. When [municipal Conservative mayor] had a thing from the Casinos downtown, we went to war. MOH supports no casino and gives a public health rationale as to why this does not contribute to community and individual and individual health."

The above quotation addresses a key trait of the Conservative-leaning groups whose focus is steeped in the market, profit-making and promoting the individual accumulation of wealth. They pay little attention to the consequences or impacts of their exploitative transactions and would not take responsibility for it either.

7.7 Countervailing Forces – External Influences

In the last section, I captured the influences of the institution, as it is coordinated, on the work experiences of the policymakers. I presented themes which demonstrated that policymakers at the BOH have experienced decreased community voices in policy recommendations from PHU which undermines the pursuit of HE/SDH; that institutional racism pervades the sites of policymaking at BOH and that has led to selective response to urgent health issues affecting racialized groups; also that HE/SDH work is sensitive to right-wing ideologies; and that the persistence of individualist thinkers within the municipal and BOH sites of HE/SDH policymaking as work undermines the pursuit of collective good. In this section we look at the external factors and how these countervailing forces influence the way BOH members get their work done.

7.7.1 Political Extremism/Polarity

One of the challenges of policymaking is the change in the political environment from one ideology to another through elections or other means. Policymakers demonstrate that such political changes at times bring in elected leaders who are extremists and may not tolerate HE perspectives. Usually from the right, these extremists tend to undermine any work that the progressive councillors propose to achieve. The quotes below summarises this dilemma quite well:

> "I was speaking to a colleague who is a suburban councillor who represents part of the northern part (wealthier) of the city, and she says that this is what it sounds like to her constituents. When someone like myself or the other progressives in the downtown core start talking about homelessness and the opiate crisis. They say, "Oh yeah! Those downtown councillors really care about the poor." And as if it was a bad thing."

Another standpoint participant elaborated on the dangers of populism as follows:

> "You know, the rise of populism is a threat to public sensibilities. It's alarming right. It should be alarming for many. I reject every form of radicalism. I mean, extremism."

The above quotations demonstrate the dilemma which BOH members who represent the equity-seeking communities have in arguing their cases for equity seeking health policy before councillors when majority are populists or are from the affluent neighborhoods. These councillors from the affluent neighborhoods may not necessarily belong to the Conservative shade, they may be simply privileged and prejudiced against the 'other', the stigmatized homeless or poor who are not common sights in the suburbs. As the standpoint participant enumerated, extremists tend to assault public sensibilities and harm decades of progressive work towards achieving HE in public policy. It also speaks to the indifference of the wealthy and powerful towards the victims of their affluence.

7.7.2 The Left Fragmentation

The policymakers decried the lack of a unified left at the municipal policy arena. The standpoint participants acknowledge that the left is fragmented such that a unified Conservative tends to win elections on marginal votes. The policymakers acknowledged that the splinter of the left has left a democratic deficit where the Conservative has made home to lurk in. As such, they warn that from their work experiences, the democratic deficit is detrimental to health because it

drowns the voices of the progressive from influencing HE policies. Below are quotes that should summarize this cogent argument:

> "And because we've lost some fights, we lost the fight for $15 wage with the election of Doug Ford, we were losing some fights, and there's lots. Why are we losing these fights? Sometimes it's because of the left splinters. We have a green party, we have an NDP party. We have, some of the Liberals sometimes are on our side, and the Conservatives have one voice from the center-right, all the way to the far-right, one voice."

> "Doug Ford can get in [elected] with 38% of the 60% of people who don't want him, and he's got all the power. How did that happen? That's because of the managed democracy that we live in. So, you know, I would call that a democratic deficit and democratic deficit is detrimental to your health (Conservative ideology)."

The above quotations confirm the concerns that without a strong left-leaning voice, HE negotiation becomes complicated. The dominance of the Conservative-leaning groups means that they work against HE while protecting the market-oriented needs assessment, safeguarding the wealth of the top wealthy 1%, and so forth.

7.7.3 Corporate/Business Sector Influence

The corporate or business interest at the provincial levels seems to be prominent in influencing public policies. This has also been shown to be the case at the municipal BOH sites of policymaking. The standpoint participants related work experiences where corporations and the

business influences have been a landmark in policymaking. Below are some quotations that validate the standpoint participant's experiencing when doing policy work:

> "So, five provinces released their no smoking by-laws. No, but it was hard for the provinces, why is it that the debate went back to the early 1990s? We had a bylaw in 1995. And when you say corporate interests, you might be meaning big corporations. So, the big corporations are influential, but it is the business sector, the business sector influence as a whole is strong."

> "Well, let's go to smoking with the big tobacco industry. And what is their argument. And they made one. And they exert a lot of power, the smoking, the no smoking-by law in restaurants is one where we fought wars."

The standpoint participants demonstrated their past work experiences where companies and big corporations/businesses worked so hard to influence voting in the council and in BOH. They believed that the looming presence of corporations at the BOH comes through as economic voices – loud enough to make it easier to understand the role of corporate/business sector influence in shaping the course of public policies and HE policymaking.

The standpoint participants acknowledged that the economic voices may actually have legitimate roles to play in public policy because they offer jobs and other services. One standpoint participant observes that these economic voices tend to fight or challenge public policies or health policies that tend to particularly curtail their economic spaces. The standpoint participant identifies

this disjuncture where they have had to find a balance between listening to economic voices and pursuing HE in health policy:

> "And, you know, when you're a councillor. When you're an academic you can afford to ask the big picture questions where there's capitalism versus socialism, you can afford to do that. When you're a city councillor, you have to deal with the here and now. And you have to deal with job losses here, job losses or job possibilities here. You have to have people coming, they have to find work. We need jobs, we need, we need people to work, we need people to participate in the economy."

> "If people don't work, they can't afford their homes. Poverty goes up. So, you know, I thought I don't think the answer is that the corporation is bad, I don't think it's a good ideological framework to pin corporations all in like purely in with one voice, all evil. Doesn't take you anywhere. You have to tame the horse."

The quotes above demonstrates that economic voices are valued – some qualified as good, and some are bad voices due to their singular focus on profit over the health of the population. It is those negative economic voices that policymakers strive to shut out of the policy making process and outcomes. However, not all the corporate/business actors are on the bad side of the policy all the time; often a give and take facilitates progress in the policymaking process. Precisely, the standpoint participants acknowledge that economic voices are transmitted into the policy process through the votes they sway. When strong lobbyists make their cases and convince board members of the impact or benefit of their voting against a policy, they win.

7.7.4 Influence of Civil Society in HE policymaking.

The role of civil society in shaping HE policy at the municipal level is well recognized. The standpoint participants acknowledged that every issue that comes up for discussion before the Board of Health, has a community of interest attached to it. They come to testify before the board to explain how an issue is affecting, what course of actions may be needed to resolve the matter and how the community will benefit from the actions. The quotation below details reflections from the standpoint participants in appraising the significant role that civil society plays in shaping HE policies:

> "A good public policy is a three-legged stool, as a political stool, we have to figure out the politics of the issue. What does the mayor think? Then we construct things within the first aspect, the problem's definition. That's an important leg of the stool. The second leg, we have to think of what the senior administration thinks. They're the professionals in the civil service. As I put it that I know nothing as a city councillor. I know a little bit about a lot of things, but I don't know much about anything. The depth is provided by the epidemiologist, MOH, the health experts who work every day and night on a particular question and make it happen. That's important. The third leg is the one that sometimes we don't talk enough about at City Hall. But if you look at every one of those issues all the issues that I've talked about every single one of them there's a community of interest."

> "There is nothing that changes in society without the engagement of civil society, nothing. So, never, ever undermine civil society. What I tell students is. I was doing politics for 27 years, and now I'm still doing politics, it just changed lanes. Right now, I'm over here, me

teaching you, this is a political act. We are together. If I get the right ideas in your brain and if you get the right ideas in my brain together maybe, we can form a little movement maybe we can change the world a little bit. That's good education and also good politics. So, it's also good urbanism."

The above quotations have summarized the validation or recognition of the role of CSO in policymaking at the BOH as a site of policy work on HE/SDH. Indeed, the momentum from the collective efforts of civil society provides a powerful political pressure that can change the course of government action on an issue. At the federal level, we saw that pressure from civil society can bring about change in government policy. A good example is mental health for Black Canadian's funding that resulted from the community pressuring the Prime Minister into action.

7.7.5 Influence of Labour Movement in Shaping HE Policy

In the interview with the BOH standpoint participants, the influence of the labour union was not mentioned at all. Even with probing them to think about the role of the labour union, most of them instead spoke about civil society organizations or conveniently clumped labour unions and movements under civil society organizations. This could mean that the influence of the labour union has faded significantly at the BOH over the years. Arguably, there could be an explanatory link to the politics of the provincial government. While most government employees are unionised, the influence of the provincial Conservative-controlled politics may have sideline labour movements and drowned their voices out of the health policy making process. However, the influence of labour movements is visible at the levels of PHUs.

In sum, the above section explored the role of external influences on the works that the Board of Health members perform in supervising, sanctioning, negotiating, voting for/against and moving the health policy forward or backward. It is within the BOH mandate as prescribed in the Ontario Public Health Standards. The chapter presented the social organization of HE policymaking as work at the BOH. It discovered that the BOH as a scene of health policy dialogue is a potential scene of conflict between councillors and highly technical PHU staff.

However, the two have always found a common ground by using the unique tools each has – BOH uses the budget tool to seek for clarity and accountability for standards and progress from PHU staff, while PHU staff water down the technicalities in their reports that may be confusing to the BOH members. Further, it was noted that BOH members are selected from a diverse pool of municipal councillors and members of the professional association, business as well as a public representative. Many of these may not be oriented or educated in health, medicine, or epidemiology and yet they have to make decisions using evidence from the health world where aggregated data has not been used frequent enough.

The section presented institutional conceptualization of policymaking as work in tailoring health policy on HE/SDH and demonstrated that the HE/SDH concepts are divisive when discussed in the same context, while when SDH is is tolerated when discussed in its own context and away from HE and social justice. Additionally, the section narrated the institutional influence over policymakers, demonstrating that the institution tolerates a decline in community voices, uplifts economic voices, promotes and retains systems that promote racism and individualism in policy and is couched within a tradition of right-wing ideology, making the promotion of health policies with health equity orientation for actions on SDH difficult. The section examined countervailing forces on health policymaking at the BOH site and found that the Conservative

ideas were resistant to the promotion of HE; left wing is fragmented and lack cohesion; labour movements have declined and have far less voices, corporate and business or economic voices were loud and embraced, while the effect of civil society organizations are were in a steady decline. These circumstances pertain in a Conservative-dominated regime in Ontario. It may be different under the influence of another political formation.

Chapter 8: The Senior Management Team (SMT)

In Chapter 7, I discussed the social organization and the social relations of policymaking at the BOH. These roles and relations are organized by provincial governing texts, namely, the HPPA and OPHS. The BOH does the oversight and quality assurance function for the OPHS and the PHU are guided by the OPHS to implement public health programs and activities. This section demonstrates the social organization of health policymaking at multiple sites of PHUs and explores first, the social organization of policymaking at the Senior Management Team level and then Health Public Policy level in chapter 9.

As explained earlier, in Ontario, the Public Health Units (PHU) report to the Board of Health (BOH) through the Medical Officers of Health (MOHs). Every PHU in Ontario – urban, urban/rural or rural – has a BOH. The MOH is the accounting officer of every PHU and all staff area accountable to MOH. By Senior Management Team (SMT), this study refers to the top Public Health Unit Managers, Senior Policy Advisers Associate Directors and Directors of Programs, Assistant Medical Officers of Health (AMOH), Medical Officer of Health (MOH), and any such persons designated as a member of the SMT of a Public Health Unit. The standpoint participants were drawn from medical officers of health in Ontario Public Health Units, directors, policy advisers and program managers as representatives of the SMT. The standpoint participants were drawn from an urban PHU and another PHU which has both urban and rural jurisdictions. Other non-public health standpoint participants were executives of research institutes, retired and former executives of their organization.

8.1 Text and Social Organization of Policymaking at SMT

As I affirmed earlier, the HPPA 1990 is the text that socially organizes the PHUs' structures. The HPPA defines the authority and relationship between the province, BOH and PHU. The HPPA further prescribes the role of each actor in hierarchical order such that the MOH at the municipal level of the government reports to the BOH. The HPPA mandates the BOH to oversee and monitor the operations of the PHU in adhering to the Public Health Standards. At the PHU, the SMT is organized around the Medical Officer of Health (MOH) who is the sole employee of the BOH. The OPHS is the second authority that textually organizes the standards of the work that the SMT does around the MOH and her associates who are medical doctors and considered field experts. The public nurses, policy experts, and other health professionals can rise within the institutional structure to the rank of program directors and associate directors. Below are the themes that emerged from analyzing texts on social organization of policymaking.

8.1.1 MOH Has Opportunities to Advance HE/SDH in Policymaking

The SMT acknowledges that to perform their work, i.e., advance HE in public health and to expand the role of public health across other critical areas of SDH such as housing and the built environment, the SMT needs the support of their respective Board of Health. The SMT finds the boards to be very supportive and understanding of this type of work. However, the MOH also wields power because every authority over public health issues and decisions rotate around MOH's technical expertise. Thus, the SMT recognizes that the MOH is powerful both as a technical person with medical expertise, and as someone who controls all resources including data and epidemiological reports that could advance HE/SDH concepts in policy, if they wanted. The following quotations highlights the above findings:

> "Board of Health that is composed of municipal representatives, local people that are either appointed locally or by the province. It's a good crosswalk of the population and in people who are sensitive to these issues and people who think so. I think having an autonomous Board of Health, as I have, and having the singular leadership in the Medical Office of Health as the sole employee of the board and CEO of PHU has been helpful to get action if you will, on these issues and also frankly to kind of rally my team around that vision of HE. Also, I think, in other situations where perhaps the Board of Health is part of a regional council or other structures of boards of health where things are much more political achieving these may be more difficult."

The above quotation implies that the Medical Officer of Health is the gatekeeper to any work done on HE at a PHU. In addition, being the technical person who advises on the impact of municipal projects and other policies on health, a properly constituted and vested MOH could actually escalate the voice of public health on HE. But this is conditional on the political context in which the MOH operates and on whether public health is itself truly oriented to address HE or not. The quote below summarizes the context in which the MOH has to operate and reveals the potential that the MOH has in pushing HE concepts forward:

> "So, I am directly accountable to the board, and so that brings with it responsibilities and powers, certainly, And I think that, in this context, if there is a leader who has a bit of a vision, or you know values as it relates to the work in HE that we can get a lot done with a supportive Board of Health."

Another standpoint participant in a similar position stated:

> "While we've also been focused on, or I've also been focused on our staff and the values and building up our work in HE. I have not ignored the Board of Health, and because if they're not supportive then it makes my job, you know, impossible in that area."

The above quotation shows that advancing HE/SDH in policy requires a synergy between the Board and the MOH without which these concepts never move forward. Conclusively, the MOH has the opportunities and resources to elevate HE/SDH concepts onto the health policy agenda.

8.1.2 Work on HE Requires Synergies of Local and Trans-local Coordination

The SMT acknowledged that the work on equity cannot be done by the public health units on their own. Therefore, external coordination is paramount, especially working with issues-based advocacy groups and the scientific community. The external actors are very important because they offer the additional voices that may counter or support any evidence that the MOH/SMT needs in order to push work on HE policy forward. This acknowledgment of the role of the issues-based advocacy group and how it complements institutional efforts are well captured in the quotation below:

> "I think if it hadn't been, and I say this with lots of humility, but if it hadn't been for the advocacy, that is, advocacy with the concrete actions, certainly that my organization has

taken in collaboration with others to help to promote the concept of HE, social and economic determinants of health, that we would never have seen progress, or received a lot longer any way to see those requirements within the care of public health offenders."

Another standpoint participant demonstrated the work experience that requires strategic preparations as follows:

"Policymaking is all about being successful. In my mind policymaking is about understanding the context, understanding the people who are active players in the context and knowing what you're seeking to advance, for what reason, and how to determine when are the windows opening because windows do open. And what can you get through the window at that time? What makes the most sense?"

The above quotation affirms the collaborative and synergistic work needed for PHU to push the HE agenda forward with emerging opportunities. Incidentally, policy windows often come when other issues-based actors may not be ready. When public health learns to be ready all the time, they could benefit from such opportunities while their issues-based partners may not be in a strategic position to benefit from.

8.1.3 SMT is a Scene of Strategic Planning and Actions

The SMT is organized in such a way that its core functioning is to strategize to benefit from discussions with the board, partners, and politicians at the BOH. According to the standpoint participants, the SMT is a scene of strategic thinking, planning and actions. For instance, the coordinated policy work done between the directors and the managers are purely strategic where evidence and politics contest and are mediated during meetings. It is here that certain decisions could be made against or for actions on HE/SDH. For instance, when the politics on an issue outweighs the relevance of evidence, say on social inequities in the population, HE concepts are suppressed. When the evidence is strong enough to suppress the politics on an issue, then evidence prevails, and HE issues move forward. It is such strategic trade-off while the SMT is being conscious of its socio-political environment that deter works on HE/SDH concepts. The quotation below explains further an experience in which key decisions were made on drug/substance use:

> "At the substance abuse level. I had a manager reporting to me. She was the policy development person at the time, who did all the work. I helped, directed and, and I chaired, along with the councillor, the interagency, inter-people committees where we had people come from different agencies, but also users. For example, I might chair that committee, but the manager would do the work of research and then we would talk about it [evidence]. We would strategize about how to go forward, both in terms of what policy recommendations we could have on the basis of the evidence that could support them or based on the politics and pressures from the community."

Another standpoint participant, describing how the strategic policy work is done at SMT, had these to say:

> "We would strategize how we were going to situate it [HE/SDH case] in a way that we could actually keep pushing it forward. Because if you needed to have it approved at a council level, how would it be moved forward, it doesn't help just to have a broad statement, right, so we tried to think underneath each of those policy recommendations, what is it that we would have to have happened either in public health unit or at a municipal level or at a provincial level for it to actually have some, some value; some meat some, some movement."

The above quotations demonstrate the nature of strategic work – planning, strategizing, collaborating policymaking as work, and coordinating that happens at the SMT as its organizing feature. The SMT is like the motherboard for PHU units for it is the site where interactions between BOH and PHU occur and where evidence from public health service delivery must be accounted for.

8.1.4 The SMT Relies on Evidence-Based/Scientific Data for Policymaking

Another important organizing feature of the SMT is the propensity for scientific evidence. While the MOH believes that other forms of science, such as social sciences and political science are legitimate sources of knowledge, the SMT leaders prefer medical, biological, and behavioural sciences. The quotes below depict her sense of science as an organizing principle or social production of preferred knowledge:

> "But public health is an art, but it is also a science, and what defines or what differentiates science is evidence. So, we must always come at it, while of course, we bring our personal convictions and our values into the equation. And yes, I would say, our politics, each and every one of us. I mean, we are human. But fundamentally, the practice of public health, should first and foremost, be about how do I bring the science to bear in order to improve the health status of the population, reduce disparities and prepare for and respond to outbreaks and emergencies."

In elaborating about the science being referenced in the above quotation, the standpoint participant attempted to downplay the centrality knowledge produced through biomedical methods using the following quotation:

> "And yes, there is the clinical sign. Right, which is a little more obvious and overt when it comes to things like communicable disease prevention control right there's a very medical feel about that. But frankly, there is also, as you know, social science, to be more precise. There is communication science. There is behavioral science. Right. All of these elements need to be brought to bear, as we seek to advance the public health goal. Right, because it's actually, you know we can't remove the political element, there will always be a certain way people will look at things through their own political lens or lenses, that that's human nature."

In the above quotation, the standpoint participant did not hide the pursuit of evidence and science in public health policy work. The way evidence is socially organized and prioritized are

well articulated. The language of 'disparities' also speaks to how peripheral the idea of equity is fitted within the organization's discourses. The emphasis that the job of public health is to 'bring evidence to bear' carries with it an allure that may undermine the concepts of HE as an activist non-scientific concept as we saw at the other levels of government.

In the above section, I presented a glimpse into the social organizing of work on HE at the SMT. The key findings are that the MOH who is an employee of the Board of Health wields a lot of power. To perform her work, the MOH has all the resources and controls data, epidemiology reports, and all other reports that she needs to push HE and SDH concepts. Furthermore, since the HPPA ring-fenced the position of MOH and AMOH to candidates with a medical degree and other health professionals can only rise to the rank of director and associate directors within public health, the biomedical paradigm seems to be favoured from the onset. The SMT has to work with external issues-based advocacy groups to complement its internal efforts at pushing for HE. The SMT is a platform organized for strategizing and bringing a balance between evidence, politics, and external influences on an issue.

8.2 How HE is Conceptualized Among the SMT

In this section, I present findings which describe how HE is conceptualized within the SMT as a critical site for decision-making on actions on HE/SDH policy. This section mimics previous sections where conceptualization of HE and SDH from within institutional realms where presented. The goal of this section is to demonstrate how HE manifests in everyday discursive and other forms of social relations.

8.2.1 HE is Embedded in Public Health's DNA

At the SMT, HE is conceptualized as a mandated requirement of OPHS and therefore the managers, associate directors, directors and the medical officers of health believe that HE is embedded into the fabrics of the institution's DNA – and manifests in all services, programs, and policy propositions. Within the SMT, the higher the standpoint participant is in hierarchy, the more they see public health as an in-built for promoting equity. One standpoint participant who heads a public health unit had this to say:

> "And so, I'm not sure how you define your HE policy exactly but certainly our push to get the provincial government to include HE in the requirements of public health in our standards is one piece, our own organization's actions in terms of embedding even before it was required of us, embedding a HE perspective in all of our work so that it means whether somebody is working as a public health inspector inspecting restaurants, a public health nurse working with local municipalities around bike lanes, or another nurse immunizing people that we put a HE lens on all of that work. So, it's not just a HE worker you know one person alone in their office who works with this but that it needs to be infused throughout all of the programs and the disciplines within our public health organization."

The above quotation supports a finding that SMT members believe that HE is an integral part of the institution of public health and an expectation. To them, HE is a public health value that may be taken for granted and more accepted now than before as a function of public policy.

8.2.2 Health Equity Reduced to Access to Health Services and Programs

Among the policymakers, health equity is addressed as making access to health services and programs possible. However, this positive perception may be utterly theoretical and lacking in all actions. The quotation below affirms this problematic. It confirms previous findings – that HE is always reduced to 'access' to needed services, and that it is less understood as fairness in the service delivery processes. Another standpoint participant makes this last point more succinctly in this quote below:

> "And this individual was lamenting the loss of those in-person ones because they felt that the teaching, could be done better in person. And I said that may be the case, but I said but did you remember why we changed it. It was in response to the clients. The clients wanted it online. After all, they couldn't make it to the in-person sessions, because they're scheduled between 8:30 and 4:30 pm. And they can't be there. So, I said it may be great teaching but frankly if it's not accessible. It's not getting to anyone.

The above quotation affirms that the HE goal is not about broader action on SDH. Rather, it is understood that equity can be celebrated as long as people have access to the resources they require. However, this is not the case, especially at the municipal level where universal programs are usually means-tested and made available based on the need of individuals, rather than closing the gap between the various classes or social hierarchies in society.

8.2.3 A Demonstrated Link between HE and SDH

Other than reducing HE to ensure that access is made possible for those in need of particular services, the standpoint participants at the SMT demonstrated an understanding of the link between policies that promote HE and its impact on redistributing SDH. One standpoint participant had the following to say:

> "Having equity or equal opportunities for health is all about ensuring that the underlying social and economic determinants of health, are addressed, are made explicit and that they're really trying to improve those opportunities more for those who have less opportunity but you know to level up that playing field and so they go hand in glove, in terms of understanding that it's, you know, under those underlying determinants that are so important to achieving equal opportunities or HE at the end of the day."

While the standpoint participants at the top of SMT believe that public health is suited to promote equity, not every member of the SMT agrees with this observation. Those who disagree with the architecture of PH as promoting HE believe that public health is not structured to address the system's change in practice. Therefore, the pursuit for equity is individualistic, relative, and subjective (the understanding varies from a person to person), access-to-services-oriented, and as such very superficially attended to.

> "I don't think that's true at all that equity is embedded in PH's gene in practice. I think it's true in theory. I think it's true in some instances, in practice. I think it isn't generally true. I think probably most people wanted it to be true. And pretty believe it to be true because it's supposedly our mission statement."

Another standpoint participant reflected on the work experience on HE as follows:

> "I think there would be theoretical agreements and undermining of the concept at the same time. I would meet with MOH and senior staff and explain the language and the strategy and emerging partnerships, and they'd be so positive and agree and say fantastic and then do the opposite later. So, you know, basically, it's about managing up all the time."

The above quotes demonstrate a contestation of the understanding of HE and confirm that there is a lack of unified conceptualization of HE and what kind of work is needed to push this forward. This view was more common with program managers who felt that some of their work that speaks directly to systems change was being snubbed by their leaders and issues requiring robust policy actions were being managed and not acted upon.

8.2.4 SMT Work is affected by its Political Environment

There is an established understanding within the SMT that promoting HE is sensitive to its political environment. The standpoint participants acknowledged the importance of the correct political context that supports health equity in political discourses. The consciousness about political context was a recurrent trend that jumped at me throughout the data analysis process. The standpoint participants acknowledged that it is more likely to move forward when the equity-issues being worked on gains momentum in public discussions, awareness, and interests. Otherwise, it is spoken about silently and nothing gets done about it. The standpoint participants had the following to say:

> "I would say though at the moment we didn't have enough of awareness amongst all of us. And I would say that the political climate was such that it was very difficult to get just about anything through [a Conservative city mayor in office]. And although we use the language of social determinants of health and social equity and HE, it certainly wasn't reflected in a very concrete way."

Another standpoint participant, talking about the political context in which they work, demonstrated it this way:

> "Although, let's say in the mental health field where I also was very involved in homelessness and mental health. You know, people were more aware of it [HE] and certainly struggled with it because the populations that we were addressing were the most disadvantaged. But the movement on it was slow and inadequate due to the politics."

The above quotes reveal that the political environment determines the work that can be done on HE/SDH concept. It informs that achieving HE in policy requires political alignment of the actors. Once an equity issue gains significant public attention, they become morally justifiable and help HE/SDH to move forward.

In sum, the conceptualization of HE at the SMT varies and depends on the rank of the policymakers. While the top SMT believes that HE is embedded in the very DNA of public health and that even if health equity considerations were not an expected health policy action goal from the province, public health units would still pursue it. Although HE is now increasingly being

accepted as a goal of public policy, actions on it depend on the politics of the environment in which SMT operates. At the SMT, policymakers who believe that pursuing HE in health policy is a function of public health units, do see the link between HE and SDH clearly.

Unfortunately, the examples of HE work that are provided to exemplify public health's pursuit of HE policy was reductionist, relegating HE policy to enabling access to health resources and services, which allude to the individualist behavioural approaches, such as access to tobacco/smoking cessation services or healthy baby programs for new mothers. Other members of the SMT do believe that HE pursuits at the SMT only exist at a theoretical level and lack concrete action. The latter category of policymakers – often those lower in ranks at the SMT – demonstrated contradiction between the theoretical view and practicality, since there is no unified institutional position on HE. Thus, the everyday work experience of these policymakers reveals subjective HE discussions, texts-based interpretations and understandings. That is because not everyone understands that the pursuit of HE means a system's change that deprives people of material conditions to live a healthier and better life.

8.3 Conceptualization of SDH

This section focuses on institutional conceptualization of SDH at SMT, and is justified because public health units interact daily with the disadvantaged population and should appreciate the reason actions that promote equity also work for SDH. Thus, the SMT require evidence to have a better understanding of how people are improving their living and working conditions, which are critical SDH.

8.3.1. Distribution of SDH is a Popular Goal of HE Policy

The SMT recognizes that the SDH concept has become increasingly popular as a health policy goal due to rising inequities in health. However, very few policymakers at the SMT actually understood what SDH is in practical terms. Most SMT members struggled in their conceptualization of how to pursue the distribution or redistribution of SDH through concrete action. Many do not find the link between enacting policies that are focused on health equity as a means for reducing inequities. Different members of the SMT understood SDH differently based on their personal experience, privileged positions, or ideological orientation. Some simply do not focus on SDH in their work at all. The quotes below help to demonstrate the conceptualization of SDH at the SMT level:

> "In addition to accepting health care being important to health, I think that over the years and certainly in this province, we've seen, you know, a real significant change; a real significant change in the political acceptance of the concepts anyway it's not necessarily the actions but the concepts."

Another standpoint participant demonstrated an emerging trend where HE/SDH concepts have increasingly dominated public discourse as follows:

> "In Ontario, by 2007 it wasn't even politically acceptable to talk about equity or social determinants of health or socio-economic determinants of health. I feel like since 2008 or so it's been more acceptable that we talk about that even within public health and ultimately as you've seen, it's been part, it's in our public health standards now."

The above standpoint participants' quotation demonstrates that SDH/HE have recently made their way into public discourse and are relatively new concepts to many policymakers, especially after the 2008 WHO Commission of SDH report. That was the major event around the referenced time.

8.3.2 Negative Impact of Fragmentation in Governmental Systems is Visible

Conversely, some SMT members actually do see the value of promoting the concept of SDH as the target of equity driven health policy work. Policymakers, however, experience a system of government that is fragmented such that policymakers work in silos. Thus, the SMT has not been able to coordinate cross-sectional policymaking efforts. A standpoint participant demonstrated how difficult it is for a policymaker from the health unit to attempt to resolve a housing issue for the homeless. The standpoint participant demonstrates that people in housing do not see housing and homelessness as issues affecting health and yet this is an important SDH. The standpoint participant demonstrated it this way:

> "I mean the system is so fragmented out there that when you're trying to get a housing for vulnerable clients, and you don't have the connections and you know they don't have it as a health issue. And I don't think that it's pursuit [of SDH] robust enough within the health unit, but I think it's pretty good all things considered, but not robust."

Another standpoint participant demonstrated situations were communicating with another department becomes problematic, especially when pursuing an issue of SDH and this is how the issue was articulated:

> "I learned very quickly to reflect on and be very strategic about what information you do share in the organization vertically. Frankly, you see what information you don't share, and realize that you don't have to share everything you do. Because it's not understood or appreciated."

> "I think that addressing equity and social determinants of health needs collaborative responses, and joint policy efforts by all stakeholders, because it's beyond the capacity and scope of a single stakeholder to address the problem"

The standpoint participant here reflects on her work within the SMT with concepts of SDH such as housing, how housing is accessed, or food and how food security should be achieved.

8.3.3 SDH Is Not a Priority of Public Health

Although policymakers at the SMT attested that SDH concept is an integral aspect of modern public health, some standpoint participants had a different work experience with SDH as a transient PH concept. The standpoint participants demonstrated uncertainty that the provincial Conservative government would use the COVID-19 pandemic opportunity to displace HE/SDH from the public health agenda. The standpoint participant expressed this concern as follows:

> "And looking at the COVID organizational design structure [reference to restructuring of PH under modernization gamut by Rob Ford] makes me feel very pessimistic for the future of equity. Unfortunately, I fear that it's not just COVID design but demonstrating what's

important to the organization and none of the prevention, or community or the work on equity and SDH are going to be seen as a priority because we all have to just focus on COVID just communicable disease."

Another standpoint participant talked pessimistically about the pandemic and the Conservative government colluding to sabotage and reverse progress already made in pushing HE/SDH policy work, leaving the people even more disadvantaged in the post-pandemic period. This is how the standpoint participant elaborated on their experience:

"So, I think it's really depressing. I wish I could be more optimistic, but I don't feel it, and the enormous forces that push the city and all levels of governments are going to be facing post COVID quite real actually. So, it's going to be harder to make progress on the social determinants and yet it's more essential than ever, ever, to do that. So, you know, we'll have to see we have to make our decision makers accountable. The best of our ability to be assessed is not easy."

The above quotation demonstrates the distrust the progressive policymakers have towards the political environment. It also affirms the fact that SDH is not a core focal area of public health because policy work on the concept can stall, be displaced, or reversed in an event of a pandemic.

In sum, the SMT acknowledges the importance of SDH, and the concept has been growing in importance and prominence in public discourses from the last decade. In fact, the OPHS makes mention of it as determinants of underlying inequities but never explains how it should be achieved. SDH are very specific, requiring specific actions to address them; for instance, housing

cannot be addressed by providing spaces in rooming houses or in transition housing. Social isolation cannot be wished away by jamming people in a mix-use mix-income housing that is devoid of socio-cultural resources. These specific actions are not being pursued. The failure to pursue specific policy goals speaks largely about the fragmentations in governmental systems which stifles inter-governmental collaborations. These silos limit resources identification, mobilization, and redistribution where need is much intense. Lastly, policymakers recognize that HE/SDH concepts may not be a core function of public health. The works that define actions on SDH may be displaced by disruptive events such as pandemics and leave many people more socially and economically disadvantaged after the disruption.

8.4 External Influences on SMT

In this section, I explore the influence of external actors on the policymakers and the work of HE policymaking at the SMT. The SMT does not exist in a vacuum; it occupies an important position of power and privilege with immense potential to influence HE policies for actions on SDH. However, what we are seeing is that HE and SDH are generally not filtering through health policies and public policies (Raphael, 2015).

8.4.1 The Influence of Provincial Politics

The SMT works in a politically-charged environment in which provincial standards of public health have to be implemented. This means that the province holds the power to fund or defund certain interventions or projects depending on the provincial government of the day. For instance, by the time of this study, the Conservative government cut funding to harm reduction and substance use treatment. At the time I was gathering data for this thesis, the Conservative

government was indulging in shrinking public health and getting everyone at the PHU upset or irritated. The standpoint participants identified that change in provincial politics has been disruptive to their work on HE/SDH policies. The quotes below explain the challenge of provincial politics:

> "I think that even just the change in provincial government and trying to make sure that we're framing things in a way that's still going to resonate that public health will still have a role in this work and not just in health protection work for example. So that is something that we need to be mindful of and make sure that we're not, I would say not coming across as too strident as it were or even political, but really that's based on evidence that this is the right thing to do."

One standpoint participant acknowledged that the actions of the Conservative government to shrink PHUs lacked evidence of effectiveness because the Conservatives were indulged in retrenchment disguised as a reform of PHUs. The amalgamation of PHU was seen as destabilizing existing work on HE/SDH concepts. Below is how the standpoint participant enumerates the work experience:

> "Not even so from a values perspective that (shrinking public health) is going to help us, for example, save money, or reduce costs in health care, and in so I think being mindful of that is extremely, extremely important. I think also being able to call on others like being able to call as you mentioned earlier the chief public health officer's report, other provinces or other documents or other actors, So, it helps it to be more normative if we're not seen as

kind of being out there left in the field but that you know there's good company. And these are the expectations of our communities and the work that we should be doing."

The two quotations above tell a tale of resignation from the policymakers due to the overwhelming nature of the change in the structure and function of public health that Ontario Province initiated in 2018/19. The standpoint participant even demonstrated fear, saying that public health is supposed to remain apolitical and not meddle in the work of politicians; however, the Conservative politicians had no regard for public health.

In practical terms, the people whose jobs are being pulled and are consequently losing income, were affected psychologically and emotionally. In the second quote, you can see that the standpoint participant was demonstrating pessimism, doubting the evidence behind the changes in public health.

The coronavirus pandemic arrived at such a time when Ontario's public health was weathering a bitter storm of transformation. The pandemic did not alter the Conservative's course of action of amalgamating PHUs. Rather, it forced a faster implementation and completion of the amalgamation process. As such, the standpoint participant was surprised that the Conservative government actually listened to public health experts on the pandemic management – the very voices they had labored suppressed. The standpoint participant reflected on her experience with the pandemic management as follows:

"I think the instincts of the organizations and people are very much in reverse of how things used to be, and I think we're beginning to see that with the Doug Ford government, they surprised us by listening to the COVID-19 experts and you know, frankly, they are not

doing a bad job. I was very surprised, but they didn't do a bad job. But now, the old ideological default position is kicking back in."

Another standpoint participant reflected on previous Conservative regimes who implemented drastic public policies and recollected as follows:

"Well, I think in terms of the external influences politically, you know, it's so much easier to tear apart than it is to build. And I think we lost a lot of ground several times in public health one was during the Harris years we lost a lot of ground and now under Doug Ford and you know, I mean that systemically, public health itself is not necessary but the things that we were developing in terms of policies, and, you know, our fights for improvements in the social determinants of health got really struck down in many instances."

In the above quote, we can see that the standpoint participants did not expect the provincial government to take advice and guidance from public health experts on pandemics. The Ontario provincial conservative government proposed in its budget 2019 to alter public health funding to 70% provincial and 30% municipal cost-sharing. In a 2019 Ministry of Health discussion paper presented to the Municipalities across Ontario, the Ministry was proposing to restructure public health into ten regional entities with the goal of streamlining services and programs such to save $200 millions.

In a response to the discussion paper, the Association of Municipalities Ontario (2020)[31] highlighted the potential effect of budgetary cuts and streamlining public health units into larger

[31] Association of Municipalities (2020). AMO Response to the Ministry of Health's Discussion Paper: Public Health Modernization.

and harder to integrate entities. AMO identified that local public health units were not filling vacant positions already, while some municipalities were financially constrained such that they have to lay off staff while and using their reserves to cover operational gaps. It is at the backdrop of this context that, the standpoint participants did not expect the provincial conservative government would effectively engage with these constrained public health units in containing the COVID-19 pandemic. The standpoint participants acknowledge that when the pandemic came, the provincial government put a halt on their moves to restructure and cut funds from public health. Thus, not only did the politics of trimming public health come to a halt, the opposition political parties and pressure groups came together to support funding and strategies that public health had put forward to be able to provide a strong response to COVID-19 pandemic and the health inequities that it exposed.

Another standpoint participant demonstrated that the COVID-19 pandemic created a situation for corporate welfare to become public, as follows:

> "So, it shifted the role of governments and so many of these Conservative, businesses, and the industry or, all we who are looking at government handouts to pay the rent to pay the, you know, keep the businesses operating, to subsidize the salaries. And yet, they'd be the first to say we should reduce taxes, we should reduce taxes, the role of government, and yes, they all turn to the government immediately in the context of when they have needs."

The standpoint participant acknowledges that the pandemic may have changed the terrain of politics and partnership by bringing an end to divisive provincial politics. The province seemed

united in the fight against the pandemic and public health seems to be working in its traditional role of containing the pandemic.

8.4.2 The Influence of Business/Corporate Sectors

The SMT perceives the influence of corporations/business sectors in a positive and supportive way. The standpoint participant at the SMT justified their regular engagement with business/corporate sector players in policy decision-making. The standpoint participants recognized that there is a need to change the practices of businesses from the single-minded pursuit of profit to taking more responsibility for people and their environment. The standpoint participants see the potential of the business sector in debating the minimum wage and ensuring a safe workplace, all of which leads to improved health for the population. One standpoint participant justified her policymaking role that hooked her work with the business sector by providing the evidence needed to demonstrate the harmful effect of certain levels of wages or work conditions. Such evidence would lead to recommendations for improved wages or working conditions negotiation. This is how she described her working relationship with the business sector players:

> "Honestly in the entire time I've been in the city, corporations have been incredibly receptive. Right. Really receptive, I think the challenge is changing the practices. Right, reorienting the corporate priorities. And actually, getting the buy-in, it's actually really, really hard within the context of a city government where, you know, Board of Health members and counselors have very personal relationships with their constituents."

Another standpoint participant drew from her work experience to challenge the logic of corporate profit-making as follows:

> "So, you're going to make money without a healthy populace. That's just not right. It's not doable. So, I ask them, let's find the areas where we're not talking about poverty, we're not an agrarian society we're not a manufacturing base. We are a knowledge economy now. And, you know, that rests on having a certain type of success in that environment, means that you have to have certain conditions in your population, one of which is good health, in every sense of the word."

The above quotation depicts the work that the standpoint participant does and the kind of conversations that she holds with business sector players. The standpoint participant approaches the business sector players with evidence to counter any possible belligerence or demand for privileges and power or their tactics to pay workers less than a living wage.

8.4.3 Influence from Civil Society Organization

The relationship between the SMT and CSOs is described as cordial. The standpoint participants recognized the potential of CSO in creating social pressure through advocacy that would elevate the political profile of an issue. The standpoint participant acknowledged that they play roles in CSO partnerships cautiously not to be caught in organizing demonstrations or activisms with the CSO. If a member of SMT is caught in a demonstration against her institution or the board, that would be considered 'subversive' and could lead to pulling funding for such a project or terminating her employment. The quotations below summarize this experience:

> "We had the capacity to work enough with CSO groups in a direct way because again, we were understaffed. We certainly worked with many different communities and civil society partners who would be more deeply embedded in those communities. Sometimes there was indirect contact with those organizations. It's very complicated as a civil servant to work on certain advocacy strategies and campaigns because you supposedly in some contexts have to stay the neutral bureaucrats and not jeopardize the funding to take a political position."

The interaction of CSO with SMT is mutually complementing in advocating for the HE/SDH issue but the CSO has a political aura that public health evades. Most times, the SMT supports the CSO platforms to build consensus and capacity to move an issue forward. However, the SMT standpoint participants demonstrated that the true capacity of public health is limited when it comes to working with CSOs on advocacy platforms because CSO is seen as assaulting the state, of which PHUs are part. This constraint also limits public health from pursuing HE/SDH with a unified voice that CSOs always put together. The quote below highlights this dilemma:

> "In terms of actually doing stuff [Activism, demonstrations], I think we're much more limited, but there's a definite role for a movement and an advocacy campaign. So, we had to judge, where we could and couldn't put our energies."

From the above quote, public health is constrained in its ability to galvanize the CSO space for its policy agenda as it was thought earlier. This is partly due to the idea that all CSO actions

are characterized by disruptive demonstrations and being actively pushy on an issue – the very point that establishment decision makers reject.

In sum, civil society groups have important roles to play in shaping public policy and equity in health policy. Public health cannot harness CSO's potential as partners to its advantage. Another potential reason that the SMT restricts itself from working with CSOs is the fear of sensationalizing an issue, especially when the press takes it on. The standpoint participants recounted an instance where CSO would cherry-pick evidence and then dwell on it to derail public health's work and dent its public image thereby straining their relationship. Thus, the challenge of working extra-locally with CSO hinges on the extent of commitment to the totality of evidence on an issue. The quote below wraps up the issue succinctly:

> "CSOs like the media tend to cherry-pick the evidence. I can find you a study on almost any subject that will basically promote what is completely wrong. A classic example. The Andrew Wakefield and immunization and that MMR causes autism. I realized that that study was pulled and was revoked. But there are many other so-called studies like this. You know, not all studies are created equal. Not all studies are well done. And frankly, shame on us. If we make decisions based on one or two studies, right? A decision should be made on the totality of the evidence, and I do mean the totality."

Another standpoint participant cast doubt on how the CSO, including the media, actually use public health or other scientific evidence to make sense of their world, which may be at loggerhead with the scientific and policy stance that public health has taken. This is how the standpoint participant described their work experience.

> "There are CSO's tendencies out thereof using the evidence not necessarily in the most appropriate ways to advance these causes, and so it becomes especially important for us as gatekeepers of public health. As a public institution, it's all about trust and confidence like we have to be true to the evidence. We have to stay; the credibility all stems from that."

The above quotes explain the reluctance of public health from bringing CSO closer, especially the media even when they should actually work closely to avoid cherry-picking of evidence. Overall, the SMT supports working with CSOs, but they do it cautiously, to ensure that controversial tendencies such as using inappropriate or incredible evidence do not erode public trust in public health.

8.4.4 The Influence of the Labour Movement on Policymaking at the SMT

The role of labour movement in the fight against social inequities was acknowledged at a time when the city is experiencing a gig economy. Labour unions are firm on ensuring that workers' rights are not undermined and are steadfast in ensuring that the SMT respects unionized workers, upholds union agreements, and enacts policies that support the worker's income and safe work conditions. At the provincial level, policymakers did not recognize the role of labour movements at all. Labour movements activities, however, are visible at the SMT level partly due unionization of a large public health workforce. The labour movement is visible in anti-poverty campaigns and discourse formulation, as well as in wage discussions and job security for its members. The quotations below summarise the influence of labour unions at this level of policymaking:

> “Concerning unions, I think they are definitely for social equity, they want that. It’s not that they don’t want it. They also don’t want you to undermine the rights that workers have won to date, right? You don't go like; I know let’s take the weekend away from everybody because these people don’t have it. That doesn’t make sense because these people have weekends, how can we get the same kind of relevant time for these people. If you can’t get the people who have weekends to work weekends, what else can we get them so that you know it's equitable?”

Another standpoint participant reflected on their work experience with the labour movement and demonstrated it this way:

> “And I mean look at the gig economy It’s terrible. It’s terrible for workers, terrible. People are getting low wages for things where you know that it’s just, and for not enough hours and, you know, the whole thing is ratcheting down. Unions don’t believe in ratcheting down. They believe in ratcheting up and I agree with them all the time. Surprise for you on the anti-poverty that makes you warm-hearted about an effort to establish a minimum guaranteed minimum income.”

The above quotes highlight the role of the labour movement and pressure that unionists exert on the standpoint participants in their roles at the SMT. Most of the public health workers are unionized except the managers and SMT members, most are not unionized. Their relationship with the unions is therefore very important in two ways: 1) the union works with SMT to ensure

that union contracts are honored, and unionized workers are afforded due to their due privileges; 2) the SMT works with the union and calls on them when an issue needs a broad coalition to raise its political profile towards action. In a good sociopolitical environment, the relationship between the union and the SMT could be mutually reinforcing.

In conclusion, the above section discussed external influencers of HE policymaking for actions on SDH at the SMT level. Key findings are that corporations/businesses have a role to play in advancing HE policies on action on SDH, such as discussions on minimum wage, working conditions, and job security. The Civil Society Organizations influence policymaking by amplifying HE issues to the political agenda of policymakers, however, the SMT is afraid to socialize with the CSO because they adulterate evidence they demonstrate, and yet, public health (headed by SMTs) is part of the provincial government. In this regard, activism is mutually exclusive of the SMT's course of action. The labour movement has a big role to play in advancing HE in cahoots with SMT – labour movements defend workers and demand for pay equity, a healthy workplace, and market income protection.

8.5 Chapter Summary

Chapter 8 demonstrated the social organization of policymaking as work at the SMT where the Medical Officer of Health is the only employee of the BOH. It was further explained how the SMT is in a better technical position to leverage resources and manpower to direct the institution to promote HE/SDH concepts in delivering public health services, programs, and innovations. One group believes that the HE concept is embedded in the DNA material and yet, this claim is not substantiated by the overall performance of PHU in advancing HE concepts for actions on SDH. The chapter further reflected that where HE concepts should have flourished, it is conveniently

reduced to ‘access’ and all other aspects of fairness and ethical imperatives to remove boundaries for everyone. The most important finding is that there is at least a general institutionalized conceptualization of HE/SDH concepts relevant to the health of the population and a popular goal for PHU’s policymaking as work.

The SMT can link the two concepts to better health outcomes of the population despite the lacking actions on these concepts through policies. This may be partly because the SMT operates from a highly sensitive political environment and interests that may require delicate balancing. Inside the institution, we see the negative impact of silos or fragmentation between government institutions which do not promote diffusion of knowledge, broader and sustained collaboration, and leveraging resources for promoting HE/SDH. This section demonstrated that HE work is sensitive to variants of political ideologies and that corporate/business influences are profound but tolerable and harnessed for health policymaking as work. The role of CSO is prominent and yet the SMT treads carefully when working with them to avoid making these issues to explicit. The role of the labour movement is stronger at this level than anywhere else, as PHUs have the largest population of unionized government workers.

Chapter 9: Healthy Public Policy Specialists (PPS)

In the previous section, I presented the everyday work experiences of policymakers who belong to the senior management team of selected public health units in Ontario. I described the social organizing of work that promotes HE in policies for action on SDH and highlighted how these concepts are understood, contested, or subordinated within policymaking institutions. I presented how policymaking as work at the SMT is coordinated and hooked onto the work of BOH and those outside of the SMT and the institution of public health. In this chapter, I present findings from a group of urban municipal policymakers whose work was defined as healthy public policymaking. This job title may no longer exist following the 2018/19 amalgamation of Public Health Units in Ontario. The concept of healthy public policy as a determinant of health was articulated at the 1988 WHO conference held at Adelaide to capture the explicit concerns for health

and equity in public policy and the accountability for its health impacts, such as evaluating actions taken on SDH (Kickbusch et al., 2008). The idea of having specialized experts designated as healthy Public Policy Specialists was to ensure that public health policies, actions, and innovations are scrutinized for their equity competencies. The Conservative regime of Doug Ford wiped these positions out in yet another signal for not being supportive of efforts to promote health equity.

9.1 Social Organization of Policymaking as Work at PPS

The standpoint participants acknowledged that what constitutes everyday work for them is determined by their managers. Assignments are communicated through a hierarchy from the SMT to the manager and each one of them. However, each department is organized by a work plan that is tailored to the Ontario Public Health Standards. According to the standpoint participants, their work setting offers a limited opportunity for collaborations or coordination with each other or with other sites of policymaking on a policy issue. As such, policymakers work in silos from one another and from other departments of government outside of public health. Typically, an assignment may include short-term or long-term policymaking, such as developing policies on the built environment, universal Pharmacare, food security, substance misuse, homelessness, and so forth. However, externally, the role of community agencies and partners is well elaborated. The job of policymaking at this level tends to be mostly desk work and less community consultation, whose significant decline was acknowledged by the standpoint participants. One standpoint participant identified working on an environment-related work for decades, trying to value the role of the built environment in preventing cancer. The following quotations demonstrate the findings above:

> "I'm just trying to think of one of the key features of my work one of my responsibilities. Well, I mean at this point like really, I think my responsibilities are around responding to needs that are defined by my manager and my senior management, like the senior management like my manager, director. Their plans are like hallway medicine that kind of thing, right so it's like basically responding to emerging needs, all determined from up above the hierarchy."

Another standpoint participant described their work as follows:

> "Well, I have to be honest like at this point I do a lot of desk work. In the past, I was doing more like going out into the community and kind of doing some consultation or engagement in the community around the downtown east work. So that was taking me outside of the building a little bit but it's a lot of desk work now. Yeah, it's a lot of like desk work"

The above quotations provide insights into the organizing of work at the HPPS policymaking site in which silos ensure that policymakers are not collaborating on emerging HE issues. The quotes also reiterate that policymaking as work may for the most part, be a desk job; however, policymakers have to interact with communities of need to get feedback on the effectiveness of public health programs.

9.1.1 Organizing of Policymaking Does Not Promote Work on HE/SDH

The standpoint participants acknowledged that the way the institution organizes policymaking as work limits policymaker's ability and focus on pursuing HE policy for action on SDH. Below are several quotations that demonstrate the impact of this social organization of work:

> "I actually was hoping to work more directly on the social determinants of health. And I'd have worked on things like Pharmacare and food security. But I was thinking that in my role and there might be more opportunity to work on things like income security and employment conditions."

Another standpoint participant demonstrated how the institutional constraints affect their work experienced this way:

> "Well, I mean, in terms of our work planning as a team. We have work plans and things are organized according to social determinants of health. But again, if I'm working on some support work for example and social inclusion, which again is a social determinant of health outlined in the public health standards. I would argue that we are not doing meaningful social determinants of health work than we're doing more than the comfort zone".

The above quotations highlight the constraints that policymakers experience in their work where they should be making policy recommendations that focus on health equity. They felt that the institutional priorities tend to stifle that work. The quotes also re-emphasize an early finding that HE/SDH is not a priority of policy work at Public Health Units. This is contrary to the widely accepted belief that HE concepts were ingrained in the DNA material of public health.

9.1.2 Management Priority Undermines Policymaking as Work on HE/SDH

The standpoint participants attributed the inability of the HE/SDH concept infiltrating health policy to individual managers or divisional heads. Some of the policymakers stated that their work may focus on issues that are not of immediate concern to the needs of the people but for political anchorage. As such, their managers often avoid working on issues such as employment (precarious work) and income (income guarantee), housing, transportation, and Indigenous status which are critical SDU but considered highly political and controversial. The managers also argue that pursuits of these SDH fall outside the realms of public health mandate as defined by the OPHS. This is how the standpoint participant observed:

> "But anything that's like kind of more immediate human-related things that enrich people's lives like issues around social determinants of health and real employment, things like, housing might be high up there [on a priority list]. Well, what about employment – precarious employment. Things like Aboriginal. Oh, yeah, we don't even touch them."

Another standpoint participant expressed uncertainty as to whether there are policymakers focused on doing HE/SDH policy work:

> "There are people in my division that are kind of doing some work on SDH/HE, but I don't think that it's a priority. So that's what I do in my role, a little bit piecemeal but that's partly because of the organizational context because there's like a lot of like flux and stuff right."

The above quotation demonstrates that the PHU operates in a highly sensitive political environment and that managers tend to be very cautious as to the choice of policy actions that they pursue. The policymakers experience a work situation where they are actually not addressing key SDH.

9.1.3 Disconnected from the Outcome of Policymaking as Work

The standpoint participants further acknowledged that despite working on a file for a long time, they are unable to evaluate the impact of their work. However, as they do policy work, their managers/supervisors provide process feedback – how the work is shaping up, and if it meets the departmental plan or not. The feedback determines whether policymakers at the Healthy Public Policy (HPP) worksites are contributing towards maintaining the OPHS and moving their assignment goals forward – whether it is policy implementation or drafting policy briefs. Standpoint participants had these to say:

> "One of the very fortunate things that have happened to me here is that from the very beginning and for two decades, I was working with a coalition, and I think that was very critical because it's not done often. It's, it's encouraged but not necessarily done."

In the above quotation, the standpoint participant hinted at the value that managers assign to her external collaborations. In the below quotation, another standpoint participant demonstrates how their work is alienated from the outcomes or evaluation results:

> "No, I wouldn't say that there's a mechanism that provides us with feedback on the impact. I think that's hard for me to say but I would guess that the answer is no. I don't think that we don't really get a lot of feedback, like, I'll send stuff to my manager, and she'll like send it back to me and want it to be revised or whatever or like give me feedback and then I do that, and then I give it to her. A lot of the time and then that's kind of it right, you don't really hear from them when they like your work. It feels like you have thrown something in the dark bin."

In sum, policymakers whose role is described as healthy public policy, experience alienation from the outcome of their work despite being provided process evaluation – meaning as they develop a policy, their managers or supervisors provide them feedback. The moment their work gets ready and submitted, they are no longer informed of the impact of that work.

9.1.4 Bureaucratic Bottlenecks Stifles Advancing HE/SDH

The standpoint participants identified that institutional bureaucracy offers resistance to HE policymaking for actions on SDH. This is how one standpoint participant described the challenge:

> "How are you going to promote like equity exactly like when the organization is so like hierarchical, like, it's just like that's like a massive contradiction right that you're like, we have this like incredibly hierarchical structure in terms of real decision-making power. And then, you're never going to actually cause a change from an equity perspective within that structure."

This bureaucratic system not only challenges HE pursuit, but also deprives policymakers of the autonomy to do policy work as they would wish. The standpoint participants reflected on the lack of autonomy in their routinized policymaking work. Part of the work experience is the lack of clarity in how their jobs are prioritized or designed. This is how the standpoint participants summarized this situation of confusions, ambiguities, and uncertainties:

> "I do actually think that an important concern that has come up in other conversations that I've heard is like it isn't actually super clear about how our work is determined. That it is not explicitly stated anywhere. But people have made that comment before. Anyway, my point is that I would like more autonomy in terms of thinking about what sort of issues we should be addressing, which policy issues we should be addressing and how to do that and I do think that is one thing that we don't do well."

In sum, the above quotation exemplifies the institutional constraints to HE policymaking that would commit to actions on SDH. From the standpoint participants' point of view as presented above, I conclude that the structural setup of the PHU where Healthy Public Policymakers work is set for failure on HE/SDH. It appears that policymaking as work at this level attends more to the politics and the decisions of the SMT managers and not the OPHS. This finding is an indictment of the provincial architectural design of PHU to undermine HE policy and yet disguise otherwise.

9.2. Institutional Conceptualization of HE

In this section, I provide more findings of how the institution conceptualizes HE. This section is important because institutional conceptual practices shape the social organizing of work and the

social organizing of knowledge. How the policymaker becomes part of the system is through socialization or institutional practice called orientation. How the HE concept is used within the institutional site of policymaking is important because it shapes the discourse that the policymaker becomes hooked onto and subsequently perpetuates.

9.2.1 HE is Popularised as Policy Goal of Choice

The standpoint participants recognize that HE is fronted as an important policy goal. However, the standpoint participants acknowledged that there are multiple meanings of HE which complicates agreeing on concrete actions. The standpoint participants had the following to say:

> "Well, I mean like, don't you think that it's sort of something that everybody recognizes as a priority? Like it's how I would say everyone acknowledges HE, whether it's superficial acknowledgment or not, right? Like, the policy work that I do, equity always comes up, but I would say again that it does not come up in a particularly meaningful way, and you know what I mean."

Another standpoint participant reflected further on her work experience in a situation her HE is ambiguously discussed, and had the following to say:

> "So, again in my training, I learned through my graduate school that, HE, depending on your theoretical perspective, can have any number of definitions. It can mean many different things. And I think that if you and I don't know if this is actually how you're using the term equity, if you don't explicitly define what you mean by HE in a theoretical

sense, then that's how these terms become kind of like co-opted and used for like Conservative agendas and stuff like that."

These quotations demonstrate the dilemma embedded in institutional work which is assumed to have been organized to pursue HE. It is a disjuncture because no one has properly defined the dimensions of equity in the works that healthy public policy people do. The Ontario Public Health Standards has its definitions of HE and that should be the standard definition to be applied in all health unit programs. This may not be the case based on the above explication of the standpoint participant's everyday work experience.

9.2.2 HE is a Check-Off Item in Policymaking Activities

Because of the contradictions and confusions, standpoint participants at this level consider HE to be a check-off item when implementing policy programs or at community engagements. One of the standpoint participants stated their ambivalence in the following words:

"The lack of clarity around what HE is part of not doing it. The fact that they're not doing it means it's like, it's a sort of handled in a really superficial way as like let's just check it off, you know what I mean? The checklist or whatever tool it is."

The standpoint participant provided two examples of how HE is poorly conceived in thoughts and actions, therefore poorly translated into action. One example is the work on social inclusion and another on employment. In both instances, when policymakers were analyzing what they have to do and how they have to do it, they realized that social inclusion consideration was

separated from the material reality of society. It's like inclusion is discussed under the radar of social, economic political, and cultural rights. To them, inclusion is participation or gaining entrance into a social group irrespective of whether that access was sustainable or not. This is similar to the dominant conceptualization of equity as 'access'.

The standpoint participant elaborated that as long as a senior participates in gardening, they are counted and checked out for social inclusion. The same scenario happens for employment when a person with a disability is employed, a headcount is done of persons with disability who get into jobs. Whether the workplace has accommodation for the persons with disability or not, or whether the nature of the job is suitable, precarious, or not, it is the headcount of the person with a disability who found a job that matters. The standpoint participant captured her dilemma below:

> "The thing is that, how are you ever going to achieve social inclusion in the way that social inclusion is defined in this work, seen from its nonmaterial dimensions? It lacked dimensions of social inclusions. How can you ever talk about social inclusion not talk about material reality like the economic part of it? It seems like I can't own a name without content or context. For example, we know health in terms of social, economic, and cultural resources. So, you cannot, for example, talk about social inclusion without a number of the other components."

In sum, the standpoint participant recognizes how the institution recognizes HE concept in a very superficial manner that undermines legitimate claims to achieve HE policy in action. This partly explains why HE and SDH may not be filtering into health policies in the province.

9.2.3 HE Concept Threatens Status Quo

The standpoint participants recognized that within the institution of public health, work on HE is perceived as challenging the power of the status quo. Therefore, to approach the work in a non-threatening space, it is best to gather diverse voices of the most disadvantaged groups, most of whom may not be very common at the decision-making levels. Otherwise, for the most part, HE policies tend to be reactionary and lack concrete action prescription. The standpoint participant had the following to say:

> "Well, I think starting from the beginning we have to get more diversity in terms of input. I don't exactly know what that looks like. But when I say diversity, I know what I'm referring to not the social world and not again just like you know people who, whose interests are basically in preserving the status quo are the people that are making decisions."

Another standpoint participant reflected on their everyday work experiences and reflected as follow:

> "We are so reactionary when we need to respond to this thing on income security/ insecurity or something else, but it doesn't look at it as a broader issue or a broader theme that we should be working on. I mean, like as a larger thing. Everything is chopped up like I'm not doing a good job of explaining this but I'm trying to get the picture. What I'm saying is that we don't take concrete action promoting equity."

The above quotation reveals the disjuncture in which the policymakers find themselves entangled daily as they try to navigate through their HE policymaking work. The lack of concrete action, coupled with reactionary approaches only confirms that the work on HE is superficial, and where it is done well, it focuses on the individual or non-priority issues that people may not need right away, such as food security, housing, social inclusion, employment, income security and so forth.

9.3 Institutional Conceptualization of SDH

In the previous section, I explicated the work experiences of the policymakers and demonstrated that the institutional conceptualization of HE and how it shapes the work on HE policy is shallow, sensitive to provincial politics, and dependent on the whims of managers and senior management team's strategic planning and decisions. Overall, policymakers believe that whatever work is being done for HE policy is not being done well, with a commitment to actions on SDH. In this section, I present findings on the institutional conceptualization of SDH.

9.3.1 SDH is Vaguely Discussed in Institutional Discourses

A robust HE policy should be able to address the SDH. What that means is that such a policy should concretely address the redistribution of social, cultural, economic, and political resources in a society. The standpoint participants' experiences with SDH concepts in their daily work is that the concept is vaguely discussed with no concrete action or goals set for it. Moreover, it is assumed that there is a role of public health in ensuring that actions are taken on SDH, Moreover, SDH is presented as embedded in the fabric of public health and yet its understanding is shallow and varies. The following quotes demonstrate these findings:

> "When we talk about social determinants of health, you clearly identify that you are expected to work on some social determinants of health. Based on where you're coming from expectations are very high. I understand that, and this is the same, that even when they talk about social determinants of Health it's so vague. So vigorous that you don't see any of the pieces coming together to concrete action."

> "In terms of like an explicit discussion of how SDH was discussed in our work. I would say that that's like generally assumed by anybody that it is one of the values that is embedded within public health. It is assumed that SDH is embedded in the institution. Right, but it isn't direct."

In the above quotation, the standpoint participant discounted the assumption that SDH is embedded in the fabric of public health. SDH concepts may be taken for granted because everyone simply assumes or falsely believes that no effort is needed to further discuss and confirm the visibility of the concept in policy, programs, or intervention goals. As such, the standpoint participants have had difficulties identifying indicators for action on SDH specifically.

9.3.2 SDH is an Expected Outcome of Public Health Actions

The perspective of the policymakers in the previous section may contradict institutional beliefs and values as portrayed in texts and public health discourses. The assumption within the institution of public health is that SDH is the outcome expectation of all public health interventions. The following quotes demonstrate the dilemma that policymakers experience while at work:

> "Our use of the term social determinants of health as outcome indicators is severely limited because the indicators, we use are usually very short term, relative to the factors that you need to look at when you're trying to change and improve the social determinants of health."

> "When you're doing an evaluation there's an outcome and then there's like the interim evaluation. So, it's instead of 'did we affect change' our indicators are 'we distributed 400' posters. We know that 600 people receive training. But whether that training changed a life or not, we don't usually have the means or time, or money to evaluate. Have we reduced the level of gonorrhea through our sexual health promotion measures? I don't know that they have the capacity to monitor."

The above quotes reflect deeply on how SDH is poorly addressed at the municipal level and how the public health units are not evaluating the impact of the programs, policies, and interventions on the targeted population. This may partly explain the focus of HE as 'access' because it is very easy to quantify the number of people who have accessed programs or interventions, information pamphlets, attended breastfeeding, etc.

In sum, the above section explored institutional conceptualization of SDH from the standpoint of policymakers and found that multiple understanding of the concept is projected and yet no concrete action is taken. Policymakers believe that public health has not done enough to evaluate the transformative impact of its policies, programs, and interventions in the community. Where such evaluation happens, public health interventionists tend to count incidences, occurrences, and attendance as measures of success.

9.4 External Influences on Policymaking as Work

In this section, I explore external influences on the HE/SDH health policymaking process within institutional sites. The purpose of this section is to demonstrate that policymaking happens locally, extra-locally, and trans-locally, thereby extending the work of policymakers from the local sites and hooking it to the work of others. Policymaking work does not occur in a vacuum, rather, it is a constellation of activities, negotiations, mediations, and trade-offs with multiple players in the issues area. It is these influences that interest me and how politics, economic voices, civil society organizations, and labour movements impress upon HE policymaking work.

9.4.1 The Influence of Political Ideology

Politics and political context have a direct influence on policymaking at every level as we have seen at the federal and provincial levels. The work on HE policy for action on SDH is inherently sensitive to the politics of the day. The standpoint participants observed that the biggest shock to their HE policy, programs, and interventions is an election. When the election returns the Conservative, then they suffer radical changes in their programs' funding. The quotes below highlight these standpoint participants' experiences:

> "Like I said before it's Conservative governments that have public health running scared to speak up about things in the society we know are affecting the health of our people and things like a National Child Care Policy, gun violence, and social exclusion. But at the same time, you know, other organizations are non-profit community social movements, have

pushed for things like the acknowledgment of Anti-Black racism and so the LGBT community has pushed. And so slowly, there's a response."

"…because there's funding it's something that happened last year, and the year before that. So, funding has been cut. There are empty roles in public health. We're not hiring. So, right. So, my team was deleted (amalgamated). We were the policy think tank of public health. We are no more. We've all been moved right under different programs."

The two quotations above describe how disruptive the political context in which HE works can be for the policymakers when elections usher in the Conservative-leaning government at both the municipal and provincial levels. Fund cutting and budgetary adjustments are often the first actions to curtail public expenditures. This study was conducted when the provincial Conservative government was settling in at Queen's Park – the provincial seat of government. Since the provinces have a mandate over public health, the provincial Conservative government announced sweeping reforms that would amalgamate public health units from 35 to 10 and cut the public health budget by 27 percent. The funding cuts did not affect public health as an institution only, they also affected community-based service providers. For instance, funding to agencies that offered harm reduction services to substance users, like the Street Health was cut without notice. These organizations support the homeless, people who use drugs, sex workers, and so forth.

9.4.2 Corporate/Business Sector Influence

The influence of corporations/businesses and economic voices in policymaking at the grassroots seems to be obvious. However, standpoint participants acknowledged that direct business-sector influences may be more diminished in one area than another.

Direct corporate/business sector influence has increasingly dominated the real estate and housing sector. Standpoint participants who work on files or whose assignment involves housing, inner-city development, built environment, and such areas have interacted more directly with corporate/business sector influences, and so are those in the food, pharmaceutical, and other areas. The following quotes explain these encounters:

> "I think condo developers and commercial developers. I think that's a huge hindrance. And also, government funding like from the province around housing. You know right now they're trying to limit Airbnb and all these things, and limit what a homeowner can do to try and make some extra income to try and create more affordable housing, and I suspect that it's far bigger factors in terms of breaks we give to condo developers. That is really affecting housing supply."

The quotes from standpoint participants demonstrated that the business sector influences tend to stir political decisions that come to the policymakers from the mayor. The pressure could send the mayor into literally fighting with the province or even the federal government for improved services in the downtown core which is the business hub and economic heart of the city, the province, and the country. This is how the standpoint participant captured this essence:

> "And then, the municipal government itself is competing with other levels of government in terms of sufficient funding for things like transit and housing. You know the mayor of the city is constantly asking for the provincial and federal government to adequately fund the transit system, being the hub that we are for business. And then answering to corporations about housing development in the cities. That's where we're very limited as well in terms of the corporate force. I also saw in food and housing I think the corporate and business sectors have still played a huge role."

Another direct business sector influence comes at the heel of any raising of minimum wage or constituting a guaranteed income security policy. The standpoint participants reported that public health is very constrained in containing or promoting these conversations because of a strong business sector influence. The standpoint participant had the following to say:

> "Raising the minimum wage; that's where, you know, our roles would be hugely limited, but I think we're making, slowly but surely, we're making ground. Environmentally speaking, you know, carbon taxing and trying to change the way we do things, how we doing them.... We're still totally answering to business and corporate sectors on that. So that areas where we have put our head in the corporate's belly."

The above quote demonstrates that minimum wage discussion is complicated and involves multiple players. The corporate/business sector voices remain strong and continue to resist any policies that reduce their profit margins. Furthermore, the standpoint participant alludes to the public health becoming submissive to the corporate/business sector influence.

9.4.3 The Influence of Labour Movement

The standpoint participant indicated that the labour union was very supportive of their efforts at shaping policy recommendations to the board. However, it has always been the policymakers who have approached the union when building consensus on key issues such as intimate partner violence. The standpoint participants recognized and appreciated the role of labour unions in the policy process, and they captured this in the two quotations selected below:

> "Although, I don't think we do well enough and there is tremendous room for improvement. What we do well that always allows civil society, unions, non-profit organizations, is we do go to stakeholders. I think we should go earlier and help them define, involve them in the definition of the problem. But we do go to them and it is in our one-to-one conversations with them, where we develop a greater understanding of the issue, what needs to be done how it should be done and they do have a role in the development of our policy recommendations to the Board of Health, as well as City Council."

Another standpoint participant provided a practical example from their previous work encounters with the labour movement as follows:

> "So, the intimate partner violence. We did talk to the union, we did talk to women's organizations, we did talk to legal organizations, we talked to the police who were unresponsive, but we do work with stakeholders. Could we work with stakeholders more effectively? Absolutely. But they do have a significant impact on the policy process. They

give us actually our most insight into issues because they're on the ground, and healthy public policy is kind of in its ivory tower in that we're in government and we're not on the front line. So, it's when we work with these groups that we develop the greatest understanding."

The first quotation describes the role of external partners including unions in identifying an issue, shaping its definitions, finding a solution for it, and spelling out the key actions needed to address the issue. The example in the second quotation cements the argument that unions have a role in shaping HE discourses, but they are not often proactive, and public health does not consult with them at the beginning of policy issues identification and problem definition phases of the policy cycle. Nonetheless, they have participated at any stage of the problem discussion when they are engaged.

9.4.4 The Influence of Civil Society Organizations

Civil society organizations are a strong force in shaping the policy process and according to the standpoint participants, they are ahead of public health on certain critical HE issues. CSOs has been able to educate the public and are instrumental in raising the political profile of an issue very quickly where public health is still looking for evidence. The standpoint participants had the following to say:

"So, right now, the Ontario Coalition Against Poverty is pushing the mayor to declare housing crisis and emergency. So, the push of those groups like OCAP has I think resulted

in public health taking a stronger role and talking about the communication of housing as a determinant of health."

"For example, if there's a report going to the Board of Health around the special issue that our coalition is working on, then the coalition can get members to send letters of support. And these are very credible people – scientists and well-known people in their own right. So, they can send letters of support, they can come up there and make deputations. So, in other words, you are supporting, you're trying to ally, you're not going against anything."

The two quotations demonstrate how the policymakers, not only value the power of CSOs, but also engage it and mobilize their support to elevate the profile of an issue before the Board of Health. The role of civil society in policymaking is critical and policymakers have to reach out to CSOs for support on critical policy issues.

In sum, the above section explicated the everyday work experiences of policymakers concerning the external influences coming from the politics, corporate/business sector actors, labour movements, and civil society organizations. The policymakers are cognizant of the impact of these external influences in shaping HE policy and yet they believe that in some situations, public health is not quick at embracing their roles, while in some instances, it depends on these external influencers to move the HE policy agenda forward.

9.5 Chapter Summary

The concluded chapter reported on discoveries of policymaking as work experiences for a group of public health employees who worked in healthy public policy units in Ontario. The

policymakers stated that they have worked on many policies that promote health equity. However, they also acknowledged that the institutional arrangements of work, structure, hierarchies, and lack of collaboration across agencies limited their work in advancing health equity. This experience was shared by a number of the policymakers, but some also identified instances where their policymaking as work to promote HE was fulfilling, long term, very collaborative, and grounded in real people's experiences. Policymakers felt that a considerable part of their work was organized depending on the priorities that their managers communicated, which often disrupted a commitment to the HE portfolio. Additionally, policymakers reported that they felt alienated from the policy outcome from the work that originated from their stations.

Moreover, the standpoint participants reported that HE is conceptualized within the institution as important, but discussions around it were polarising. When HE is to be imbued in policies, programs, and innovations, the standpoint participants felt that HE was to be a check-off item. In the same breath, while SDH is considered a goal of public health actions, it was vaguely discussed, never integrated into the mainstream, but spoken about in passing.

The standpoint participants identified various external influences that they encountered while doing work on policies that promote HE. For example, they recognized that HE/SDH concepts are very sensitive to the political environment. This is more so to the Conservative sociopolitical formation than the Liberals and left-leaning tendencies. The corporate/business sector is the commonplace at the community levels and their role in promoting policies to address SDH as recognized, embraced, and justified. Labour Unions are very supportive and civil society organizations are the mainstay of community-based advocacy groups with really strong voices for health equity for action on SDH

Chapter 10: Discussion of Findings

Institutional ethnography's focus is on the individuals and their grounded subjective experiences in the work they do, how they do what they do, and how the work that they do gets hooked to the work of others (D.E Smith 1987; 2006; 2005). By mapping out this work process, a researcher discovers relations of ruling that socially organize people's work experiences at the worksite and the knowledge that is produced from and informs that work. IE is a sociological mapping of social interactions of rules and governance and offers inquiries into the social relations that shape the inner workings of institutions (D.E. Smith, 1987, 1999, 2005, 2006). In this study, I took the standpoint of policymakers – individuals whose everyday work constitutes and contributes to making health policies that promote HE in various institutional sites. The institutional sites of study represented policymaking sites at the three levels of government in Canada. At the federal level, I studied PHAC, at the provincial level, I researched the legislative arena of three English-speaking provinces – Ontario, Saskatchewan, and British Columbia – at the municipal level, I focused my studies on Ontario's Board of Health and Public Health Units.

While acknowledging that policymaking is not work attributable to an individual, this study recognizes the complex nature of the coordinated sequence of policymaking as work done by individuals in work attempts to produce equity in health policies to augment actions on SDH. The study demonstrated that health policymaking as work that occurs in the various institutional sites entails multiple sequential activities that are majorly textually and discursively coordinated; although some other forms of coordination may exist. It further confirmed that policymaking as work is itself text-dependent, text-heavy, text-producing, and text-governed. Thus, various levels of texts shape the relations of ruling that create the social organization of policymakers' knowledge of policymaking as work or work-related activities. The ruling relations are those institutional

structures that regulate, reinforce, govern, guide, and standardize the works of individual policymakers and constitute the institution and its conceptual practices (D.E. Smith 1987, 1990, 1999, 2005, 2006). Typically, data analysis from interactions with the standpoint participants combined interview data with analytic work on texts that came to prominence during interviews with the standpoint participants.

At the federal level, I examined the relations of ruling that govern and socially organize policymaking as work for achieving equity in health policy for the distribution of SDH. At that level, I identified key boss texts/high-order texts, namely, the Health Minister's Mandate Letter and subordinate texts such as the PHAC Act (2006); and the Departmental Plan for critical analysis to locate how HE/SDH concepts were presented, discussed, defined, made explicit or implicit; visible or invisible. The goal of the IE project was to make visible the invisible (D.E. Smith 2006; 2005) Critical discourse analysis was a subjective exercise in which I took time to analyze how HE and SDH are embedded in coded high-level communication among politicians and policymakers (Raphael, 2011a; Tummons, 2017).

The analyzed texts offered insights into how HE/SDH concepts are worded, presented or absent, prioritized, resisted, subordinated, or neglected all together in the regulatory and governing texts that shape HE policymaking. Using a technique of mapping the ruling relations (D.E. Smith 1990, 1999; Turner, 2006), the texts illuminated the social organization of the daily activities of the policymakers at institutional sites to gain better insights into policymaker's everyday activities that constitute policymaking. These texts are complemented by other texts, memos, website materials, and internal text-mediated communications that are activated at multiple institutional sites to coordinate policymaking locally and trans-locally. Thus, the texts illuminated that HE is scarce in institutional discourses, problematized as difficult to communicate, hard to measure,

targeted to the disadvantaged, and ambiguously communicated allowing for multiple interpretation of its meaning, thus the lack of concrete actions on it. Scholars in this research field have argued that in Canada, despite the rhetoric about reducing health equity by enacting health policy with equity goals pervades policy agenda, it has not been achieved (Raphael, 2008a, b; 2013; 2015a, b; McGibbons, Fierlbeck, Ajadi, 2021). Thus, this study, through its texts analysis, attempts to provide insight as to why achieving health policy has lagged.

Analytical discoveries demonstrated that the concept of equity was poorly communicated, transmitted, and perceived differently at various institutional sites, with the most common understanding of equity reduced to 'access' to services, opportunities, and resources for health. This understanding of health equity is inherently limiting and speaks to the general lack of commitment to health equity. The lack of demonstrable commitment to achieving HE in compels critics to identify that equity-seeking health policies are hard to come by (Raphael, 2015c; Scott-Samuel & Smith, 2015).

Through institutional analysis, this study demonstrated that there is a general will in government circles to improve the redistribution of social and economic resources necessary for the health of Canadians most in need. However, there is no consensus at every level of government and institutional policymaking sites on how to achieve this goal. Most of the activities that were named or identified as heath equity work tend to target the disadvantaged and focus narrowly on individual behaviours. McGibbons et al (2021) identified what they called "biomedical imperialism" as an element of social organization of policymaking as work (p.69). There is awareness in some quarters within government institutions that health inequalities have pervaded Canada and that something must be done about it. However, this intention is communicated vaguely and often steeped in governmental institutional bureaucracies and departmental silos.

While higher-order texts made references to both the concepts of HE and SDH either implicitly or explicitly, there was no explicit link between the two concepts, and often, HE was considered a temporary aspect of public health work that gets displaced by other emerging priorities, such as the pandemic or cost cutting measures. Key decision makers in a corporatized institutional setup did resist the concept, such that HE/SDH concepts are outcompeted by other issues from getting onto the policy agenda. These responses constituted the institutional conceptual practices which are quite hard to change. Raphael et al (2021) acknowledged that institutionalist structuring of policymaking tends to be resistant to change as they adhere to formal rules of operation, organizational structures, and their standard operating procedure. Sinclaire, Schultz, Linton and McGibbons, (2021) observes that certain institutional traits are historically oriented to empiricism and relegates accounts of the policymaker's lived experiences from the standardized institutional practices. Additionally, the extra-local interactions in which the institution of policymaking engaged in, with external influences such as the corporate entities, labour movements, civil society, within a political context tend to restrict choices for policymakers as the institutions tend to adhere to well-tread policy approaches. This study points to a pattern of depoliticization and use of ambiguities to escape commitment to HE policy work as an institutional conceptual practice.

Where HE and SDH was mentioned or recognized explicitly within the institutional discourses, the elements were listed as discrete with no connection between them and HE policymaking. Moreover, the gatekeepers of public health such as Chief Medical Officers of Health and Chief Public Health Officers articulate the concepts of HE as a goal of health policy and yet none focuses on addressing structural issues of redistribution of power and resources for health. Several studies demonstrate that CMOs and CPHOs are ineffective in many ways; Fafard,

McNena, Suszek & Hoffman (2018) observes that while these officials are senior government advisers, perceived as independent communicators and advocates for public health, these roles varied considerably across Canada with their power not clearly identified in authoritative texts; found that for the gatekeepers (CMOs, MOHs, CPHOs), ideological orientations and consciousness matters and that issues of epistemological variations among these officials was key to promoting work on health equity (Brassolotto, raphael & Baldeo, 2013; Raphael, Brassolototto, and Baldeo; 2014; Brassolotto & Raphael, 2015;); Farfard and Forest (2016) identified the powerlessness in current structural arrangements at PHAC or the CPHO; Townsend et al (2020) argued that how these officials may frame their interest may also determine the outcomes of the policy. Thus, the lack of a clear institutional consensus on how each SDH would be distributed or made available other than taking the disparities approach to it. By reducing HE to 'access', there was no demonstrable evidence that policymakers at these institutional sites across the various levels of government were situating HE concepts within its cognate of social justice and using it as a measure to determine redistribution of SDH.

The study further demonstrated a lack of concrete health policies, programs, and innovative ideas that were upstream enough to tackle health inequities. For instance, most of the programs at the federal level were tailored to targeted groups for public health and recommended health behaviour change through funding, research, and knowledge dissemination. In this way, the study concludes that across all levels of government, the HE concept was not being pursued in its rightful context, i.e., context ripped from social justice and not focused on closing gaps (Marmot et al, 2008; Graham, 2004; Smith, Thompson & Upshur, 2018)).

Additionally, the institutional bureaucracy and its structural layout were a challenge for HE and SDH concepts. The PHAC as an institution is organized such that it is corporate governed

with the CPHO's authority reduced to an advisory role. The corporatization of the institution is one confirmation of how neoliberalism influenced government institutions and usurped policymaking as well as health policies across Canada (Bryant, 2016; Coburn, 2013; Rushton & Williams, 2012). The study affirmed that key decision makers within the policymaking institutions may not be oriented to HE and SDH concepts, or simply are there to resist these concepts altogether. The institutional actors with much of the decision-making powers have a business and political or corporate background while the policymakers at the frontlines are very well qualified, grounded, and experienced with HE/SDH concepts. The study demonstrated that various actors located at different social locations above the policymakers whose standpoint the study took, the institutions have powers to resist or remove or conceal these concepts from institutional texts as they wish. The bureaucratic nature of a corporatized institution undermines the evidence and commitment of the standpoint policymakers who are highly qualified, experienced with, and legitimately invested in the pursuit of HE in their everyday policymaking as work.

Additionally, within institutions, the study found that the biomedical practices pervade the social and ruling relations such that the social organization of knowledge is 'scientifically generated' and policy outcomes are 'evidence-based'. Through text analysis and mapping, multiple problematics became apparent. Policymakers within the institution recognized the contradictions between the institutional setup, the bureaucracy, the prevailing conceptual practices, and the dearth of consciousness on the part of high-ranking decision makers on HE/SDH concepts that makes policymaking as work difficult and frustrating. The dominant institutional practices are entrenched to obscure HE and to privilege traditional and market-oriented practices. These practices are in sync with the hegemonic biomedical paradigm and ideologies that target individuals and individual behaviours and seek individualized remedial interventions for

behavioural change while assuming that individuals need mostly knowledge to alter their risky behaviours.

That is how the institutional language such as ‘evidence-based’ policymaking and using ‘scientifically produced evidence’ have not only precipitated the objectification of the policymakers and their subjective everyday experiences but has also worked to undermine how HE and SDH are negotiated and articulated discursively and textually. Rankin (2017) has identified ideas that circulate in the “authoritative” discourse as those that arise “ideologically” inside the ruling ideas (p.5). Thus, according to the conceptual practices of these institutions, only policymaking and policy outcomes that arise out of “scientifically produced evidence” qualify as legitimate. Some studies have suggested that there is a need to enhance the uptake of scientific evidence among decision makers to augment the uptake of scientific evidence (Campbell, Redman, Rychentnik, et al., 2009; Oliver, Innvar, Lorenc, Woodman, & Thomas, 2014). Such suggestions would support decision makers with business and political science backgrounds to understand health policy research as they make decisions on HE outcomes through actions on SDH. Petticrew and colleagues found that policymakers rejected HE evidence for weak underlying theoretical evidence and claims that it lacked evaluation for effectiveness (Petticrew, Whitehead, McIntyre, et al., 2004).

Additionally, D.E. Smith (1990) argued that the materiality of ideology is itself produced through a method that centers on canceling of the subject(ive) within an institutional apparatus. In this case, disregarding the subjective experiences of the policymakers who implement, test, evaluate and recommend policies, programs, and innovations that matter to Canadians undermine the pursuit of HE.

The objectification of subjective knowledge produces the so-called factual accounts of different kinds known ordinarily as records, statistics, news, data, databases, files, and more (D.E. Smith, 1990). The inclination towards scientifically-produced evidence is part of the conceptual institutional practices used to undermine work on HE/SDH concepts within the complex workings of this institution which considers these concepts as hard to measure and conveyed vaguely as activist concepts. Consequently, a good number of health policies, programs, and innovations attributed to these institutions have three characteristics: a) providing information by assuming that the targeted groups lack information to make better decisions, b) striving to gather evidence whether the knowledge has permeated and potentiates health behaviour change, and c) providing funding to groups and community organizations to change health behaviour or create an enabling environment for individual health behaviours change to occur. The trend is replicated across the three levels of government at which public health is regulated and delivered.

The scene of health policymaking at the federal level is also a place for great ambiguity in communicating HE and SDH concepts. There is a lack of a unified working definition of HE or SDH in texts and discourses as such every institutional site interprets and uses these concepts as they wish. Thus, the way the governing texts are operationalized or gets activated is based on the readers' interpretive practices at the local sites. Consequently, the lack of consensus on these HE/SDH concepts means that some policymakers view the concept as a process, product (outcomes), or measurement/tool for health policy – a taken-for-granted concept that means anything and nothing simultaneously. It is safe to conclude that the ambiguity, in this case, is also part of the conceptual practices within the institution in which both the biomedical and neoliberal ideologies reside and collude to perpetuate health inequities. Again, these patterns are visibly identifiable at the provincial and municipal levels in Canada.

The policymakers' individual experiences with the concepts of health policy and SDH also vary depending on the policymaker's roles and assignment, practices across institutional sites, and the level of government. However, the common experiences are that policymaking as work on HE/SDH takes time, preferably 5-10 years, for tangible results and needs a steady supply of resources. Invariably, the policymakers acknowledge that the institutional setup makes HE hard to communicate and measure, which means the concepts tend to be subordinated due to the burden of its evidence that is considered low on evidence rank (Shah, 2003).

The policymakers see that HE/SDH concepts are operationalized at the grassroots/communities which is distanced from the institutional decision makers' everyday subjective experiences and therefore, making it hard to justify, account for, advocate or explain these concepts in policy recommendations. Nonetheless, while the traditional approach of targeting the disadvantage has prevailed and continues to create the 'othering effect', a new generation of informed and critical policymakers is emerging to push for a paradigmatic shift from targeting the individuals to closing the gap (CSDH, 2008; Graham, 2004; Marmot, Friel, Bell, et al., 2008).

Closing the gap seems to be the new agenda that offers a convincing alternative and a better prospect for the HE policy environment. This area should be navigated further by emerging scholars and researchers to expand the idea and begin building a stronger supportive culture for it to evolve among policymakers. At the federal scene, strides are being made, especially in deconstructing the concept of equity as closing the gap through visual cues – posters and graphics. At the provincial level, the closing the gap concept was not mentioned at all while at the municipal level, the health policy specialists were quite familiar with this concept and sought opportunities to pursue it in the healthy public policy agenda. Unfortunately, the Ontario provincial Conservative

government restructured public health units and obliterated the position for healthy public policy as part of their cost-saving reforms in 2019.

D.E. Smith observes that an institution impresses upon its actors' certain influences which becomes part of the conceptual institutional practices and therefore, identifying those influences is an important analytical undertaking of IE (D.E. Smith 1987, 1990, 2005, 2006). The policymakers recognize that while key decision makers may not be oriented to the HE/SDH concepts, the institution further depoliticizes work on HE. As public servants, the policymakers are expected to not display their political views in their work but allow evidence and facts to prevail irrespective of where those arise from. Thus, policymakers are to depend on what is considered objective evidence and established institutional practices, which objectifies the policymaker and alienates them from their experiential knowledge. Depoliticization or political neutrality in public institutions has been attributed to state agencies that are increasingly adhering to the principles of the neoliberal state agent. Under such circumstances, state interventions are enacted through an ongoing engagement of market agents and public institutions that precludes the politics of policymakers (Etherington & Jones, 2017; Jessop, 2014, 2016). Depoliticization, therefore, conceals the politics of the market and the state, and prevents questioning policies that are tailored and steeped in market-oriented language and goals, such as 'investing in health', 'broad-based collaborations with the private sector', et cetera.

Within these institutions, disruptions to HE/SDH policymaking efforts often occur, such as when change in government, leadership, or a sudden transfer of a policymaker who has a commanding grasp over a policy issue. Usually, when a staff transfer occurs, the policy issue that such a staff was pursuing is shelved, incorporated into another ongoing work, or subordinated under another departmental assignment. Another disruption to policymaking as work to promote

HE/SDH comes when elections happen. The new government releases new ministerial mandate letters which set the pace for a totally new priority that may alter the course of actions on HE/SDH policy work. Additionally, policymakers are concerned with the effect of departmental silos that tend to limit the diffusion of information, ideas, and important timely evidence needed to support work on HE/SDH. Policymakers recognized that the pursuit of HE/SDH is becoming more of a performed act (no real commitment/lip service) by ranked officials. In an actual sense, the dominant practice remains to target the disadvantaged or individualist approaches with little upstream measures.

Policymakers acknowledged that HE/SDH is not a permanent feature or a fully accepted aspect of the core work of public health agencies, such that these concepts are easily displaced by other emerging political priorities or health emergencies which are viewed as core functions of public health. A good example is the pandemic management that had sidestepped ongoing work on HE policy. It was the same pandemic that unveiled and re-directed attention back to the pervasive health inequities that were being swept under the rag. This led to the CPHO recognizing and recommending equity measures needed to reduce the inequity gaps as part of the pandemic containment measures in her 2020 report. At the provincial level, similar measures towards recognizing the widespread inequities were undertaken but with much lacklustre enthusiasm compared to federal government responses. At the municipality, PHUs mobilized and demonstrated how effective public health as an institution is in pandemic or disease management. Public health's effectiveness in pandemic management offers insight into how effective the system could be when it commits to equity-driven policies.

The policymaking sites is not a stranger to external influences. At the federal levels, inter-governmental collaborations are encouraged, however, that happens only at the political level. Its

effects do not filter to the policymakers to the extent that discussion of key determinants of health such as minimum wage, labour relations, and housing is off-limits to policymakers in health as these issues may not gain due attention as health related. Thus, while the influence of labour unions on HE/SDH is widely recognized (Bosch, 2015; Grimshaw, Bosch, & Rubery, 2014; Pilon, Ross & Savage, 2011), the union's full participation is lacking in the discursive realms at the federal and provincial sites with some visibility of the labour movements at the municipal level. Civil Society Organizations (CSOs) however, remain visible and loud. CSOs have played a big role in shaping health policy at all levels of government, by taking the responsibility to force governments to take certain actions to reduce social and health inequities. CSOs were cited as being instrumental in pushing for actions to alleviate poverty and reduce the isolation of first nation people and promote Black mental health.

Corporate influence is pervasively visible and their participation in health policymaking is justified at some sites of policymaking, especially at the provincial levels. In some sites, however, corporate/business influence may appear subtle or concealed. Depending on their assignment and institutional location, some policymakers were not directly exposed to, or unaware of corporate influence. However, corporate influence is well recognized and is on the increase across the three levels of government. Policymakers' experience is that corporate influence is more intense at a higher policy-making level, and it is resisted at times. For instance, when shaping the food policy and updating Canada's Food Guide, the government of the day resisted corporate influence. Such instance of resistance, however, was rare for participants in my study to refer to.

The influence of political ideology is a recognized factor in HE policymaking (Baker, Frail, Kay, et al., 2018; MacKinnon, Gómez-Ramírez, Worthington, et al, 2020). Policies are a statement of action that transmits a certain ideology (Bryant, 2016). Policymakers' experiences are such that,

HE and SDH concepts are sensitive to political ideologies in Canada across the levels of government. According to the policymakers, work on advancing HE/SDH is resisted, declines, or subordinated the most during regimes of the Conservative Party. This experience is found across all levels of government. The Conservative Party tends to privilege corporate or market-oriented development; and therefore views the distribution of SDH as a market mechanism function (Banting & Myles, 2013; Thorburn & Whitehorn, 2001).

This study did not explore the impact Canada's social democratic tendencies have had on minority governments at the federal level, in combination with the national questions in Quebec, and how that is creating a 'contagion effect' on policy at the provincial level. The reluctance of some standpoint participants to engage in an in-depth discussion of political ideology was associated with depoliticization among staff both in federal and provincial levels, emphasizing their non-partisan institutional tradition. Besides, not all the participants were aware of the role that political ideologies or labour movements play in shaping HE policymaking from outside the institution in which they operated.

Furthermore, it was difficult to compare the achievements of NDP and left-leaning political organizations elsewhere; say Quebec or British Columbia with their role in Ontario. This was particularly difficult when interviewing participants who lived and worked in Ontario or those in British Columbia. In Ontario, most participants exuded little enthusiasm about the prospect of an NDP government. Furthermore, many could hardly recall when the NDP last dominated or were in opposition, like Jack Layton's and Olivia Chow's years. The stereotype that the left-leaning forces are weak, was the dominant theme from the data. It is therefore recommended that a future study explores how the NDP is resisting or co-opting neoliberalists and the role of left-leaning political organizations in Canada in shaping HE policy.

This study adds knowledge in the health equity and health policy debate by creating an alternative critical analytic direction that is neither pluralist nor institutionalist. Its focus on what policymakers actually do, and how the institutional set-up in which policymakers work influence what they do, makes this study unique. Additionally, IE allows a focus on illuminating a particular historical and discursively coordinated social relations. Thus, IE has enabled us to further examine of how HE concepts is applied and how SDH are considered in policymaking as work. Policymakers' subjective experiences in policymaking as work to advance actions on SDH through enacting equity-based policies are few (McGibbon et al, 2018; Townsend, Langille & Ripley, 2003; Ng, Stooke, Regan et al, 2013: Ng, Bisaillon & webster, 2017.

IE has made explicit the processes of policymaking as work that is usually difficult to identify and articulate. IE allows for the critical examination of processes that are usually taken for granted. There is need of activating HE text as the ruling relations within the current positivist hegemony within these institutions of policymakers. Future research could explore how the barriers identified in this research have been overcome in other jurisdictions both within and outside of Canada. These would involve examination of the role that political ideologies of governing authorities and parties both facilitate and hinder such actions. Similarly, how different forms of the welfare state either facilitate or hinder the achievement of health equity can be further explored (Raphael & Bryant, 2006; Raphael, 2015a). Finally, the role that the economic system plays in promoting health equity by either constraining or hindering policymakers' efforts appears to be a ripe area for inquiry (Raphael, 2015a).

10. 1 Potential Limitations of the study

Much of the limitations of my study, are based on the nature and design of IE, for instance, scholars have critique IE for relying on experience as data, concerns over structuring of language which makes IE reports inaccessible; and the search for subjective accounts of people that is not objectified as in other studies (Townsend, 2008; DE Smith, 2005; Devault & McCoy, 2002; Walby, 2016). These are legitimate concerns which should, however, survive problematization. Walby (2016) stretches further that IE lacks a focus on social relations of research and thereby does not account for the relations that the researcher makes with the standpoint participants and the data that arises from that interaction. However, IE critiques have to contend that IE as a method of inquiry facilitates a comprehensive understanding of an individual's doing (Prodinger & Turner, 2013).

To overcome these limitations, I drew authoritative and corrigible accounts based on actual work experiences of policymakers drawn from their everyday work process. Further, DE Smith (2005) emphasizes that IE does not study people's or their problems, but an understanding of the problematic within their social world. I found DeVault and McCoy (2006)'s guidance that the role of IE researcher is to develop knowledge of the institutional process which opens doors for a kind of listening and probing of institutional connections quite empowering. I went into the data collection phase with much consciousness of what is required of me, as an IE researcher. By practicing both reflective and reflexive thinking, it helped me to remain conscious of my role and to stay afloat as a researcher with work experience like those that I investigated. Being conscious of one's situatedness in research helps them to check for their own biases, capture biases from the participants, and escape institutional capture (DE Smith, 2005).

I have worked in public health for over a decade and the risk of institutional capture was high. However, this risk would not have been as high as that which could confront a researcher

with little or no work experience in public health, or with little or no preparation in IE. To avoid institutional capture, I chose not to reveal my own everyday work, profession, or practices to the standpoint participants not for deception, rather, to avoid biases. This decision ensured that the standpoint participants did not suspect or expect that I understood their institutional discourses and language. The decision to leave out my work experiences allowed me to probe the unconscious use of institutional language, slangs, and lexicons that are taken for granted but masks work experience details. I was able to dialogue and explore concepts within the institutional discourses like a curious outsider with a blank mind. My focus on text and text mediated ruling relations, and social organization of work remained steadfast (Norstedt & Breimo, 2016).

Another limitation that was personal was unpacking the IE language itself steeped in feminist sociology and variations of Marx's materialism. The use of IE requires a preparation in critical materialist political economy but also a deeper understanding of sociological concepts, including both the ontological and epistemological roots of sociology and ethnographies. In this case concepts that focuses the attention of IE researchers on work related experiences and its social organization becomes critical. I hope readers who may lack these foundational preparation in this field will find comfort in the terminologies and concepts I deploy in this thesis. The strength of this study is that I spoke with standpoint participants from a wide range of professional background. The work experiences described and the problematic therefore transcended time, political contexts, and major health events such as pandemics. These experiences added insights into the work experiences of those working to advance health equity concepts in health policy through actions on SDH.

10.2 Conclusions

In sum, this study has illuminated some interesting processes and institutional characteristics that could explain why health equity considerations may not be filtering through health policies developed across the three levels of government. Policymakers have demonstrated resilience in their everyday work of advancing HE/SDH concepts amidst many institutional complexities that offer a mixed bag of opportunities whose potentials are not harnessed to promote health equity. Inspiringly, those who identify as policymakers are highly qualified and experienced in their work on HE for actions on SDH. What is clear for all levels of government is that there is no legitimate effort at achieving HE in public policy due to increasing corporatization of public institutions, the hegemony of the biomedical traditions, a bloated bureaucracy architecture, and conceptualized institutional ambiguities around these concepts that cause difficulties when building consensus on actions in order to achieve equity policy goals.

The weakening of the role of labour unions and political parties or voices from the left-leaning movements have afforded room for economic voices to increasingly become amplified over public policies. Additionally, the decline in community consultation has led to the exclusion of community voices in the HE policymaking process. The fast-changing social and political environment which corresponds to increasing social inequities may be pointing to the increasing influence of neoliberalism over public policy processes – a situation that Farrer and colleagues described as the "contemporary economic and political zeitgeist"(Farrer, Marrinetti, Cavaco, et al., 2015. p.418). The biggest obstacles to achieving HE policy across the various levels of government are the Conservative ideology, hegemonic biomedical approaches to explaining health, institutional conceptions that context-rips equity from social justice, and the rising tides of neoliberalism, more so as seen at the federal and provincial sites of policymaking.

There are numerous barriers to addressing health inequalities through public policy action in Canada. Lynch (2020) identifies three taboos that limit the addressing of health inequalities that she links to welfare regimes: Liberal: redistribution; Conservative: public spending; and Social Democratic: market regulation. All three taboos appear to apply to Canada, suggesting a profound need to raise the volume in research and advocacy (Lynch, 2020). This study offers insight to political organizations of the left and labour movements to step up, be heard, and be seen in actions that support HE policymaking across governments. Corporatization adversely subverts legitimate efforts to achieve HE through policies for strengthening the redistributive functions of the Canadian welfare state. Policymakers have opportunities to pitch for a paradigmatic shift, from the biomedical approaches of targeting the poor to closing the gap. Achieving this paradigmatic change is difficult, maybe gradual, and painstaking. Nonetheless, it offers a scintilla of hope for the new generation of HE enthusiasts, scholars, researchers, advocates, and practitioners within government's institutional sites. HE can be achieved if it is transplanted and pursued from a social justice context. This study concludes that epistemologies rooted in hegemonic biomedical and neoliberal conceptual practices within the selected institutions dominate the ruling relations and the social organization of policymaking as work in these sites; and that, the gap between HE concepts and government commitment to health policy for equity demonstrates a lack of commitment to action on SDH in an increasingly market-oriented and politicized policymaking environment.

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Appendices:

Appendix 1: Sample Public Health Agency of Canada 2021-2022 Supplementary budget Information. This table highlights spending priority in the 2021-22 Department Plan.

Transfer programs of $5m or more				**Evidence of Effectiveness**
Policy Program	Departmental Result	Start of Funds	Targeted groups	Performance Indicators
3-yea plan for Canadian Prenatal Nutrition Program	Canadians have improved physical and mental health	1994-95 on going $27,189,000	**Purpose and Objectives:** Target child-maternal health in Canada Non-profit organizations Municipalities and local organizations; and, Other Indigenous organizations.	**Expected Results** Number of CPNP program participants (pregnant women, postnatal women, and other parents/caregivers); Percentage of CPNP projects that leverage multi-sectoral collaborations (i.e., have more than three types of partners) to support pregnant women, postnatal women, and families facing conditions of risk.
3-year plan for Indigenous Early Learning and Child Care Transformation Initiative	Results 1.1: Canadians have improved physical and mental health. Link to Health Promotion	Started 2018/19 anticipated end date 2027/28 $29,500,000	**Purpose and objectives:** Support the implementation of co-developed Indigenous Early Learning and Child Care Framework. The framework reflects the unique cultures and priorities of First Nations, Inuit, and Metis	**Expected Results** Number of participants reached. Percentage of AHSUNC sites offering activities (e.g., elder participation, storytelling, traditional ceremonies, etc.) to increase Indigenous cultural knowledge. Percentage of participants/parents/children who experience improved protective factors as a result of programming (e.g., access to cultural activities); and,

			children across Canada. Object(s): The initiative enables greater control of IELCC through a new partnership model to facilitate Indigenous-led decision-making to advance national regional priorities. Employment and Social Development Canada (ESDC) is the federal focal point guiding this horizontal initiative, with Indigenous Services Canada (ISC) and PHAC as key federal partners.	Percentage of participants/caregivers that report that their child's health and wellbeing has improved as a result of programming.
Policy Programs under $5m				
3-year plan for Addressing the Challenges Faced by Black Canadians	Result 1.1: Canadians have improved mental and physical health. Link to Chronic Disease Prevention	Start Date: 2018.19 anticipated End Date 2023/24 2021/22: **4, 175,000** 2022/23: **1,725,000** 2023/24: **1,640,000**	**Purpose and Objectives** The new Promoting HE and Mental Health of Black Canadians Fund will support Black Canadians to develop more	**Expected Results** Target populations participate in healthy living and chronic disease prevention interventions. Social environments are improved to support ongoing healthy behaviours Project participants have the knowledge, skills or ability to

			culturally focused knowledge, capacity and programs to improve mental health in their communities. This program will also: Increase understanding of the unique barriers to and social determinants of mental health for Black Canadians Increase knowledge of effective, culturally focused approaches and programs for improving mental health and addressing its key social determinants for Black Canadians, including a focus on youth and their family and community environments; and, Increase capacity within Black Canadian communities to address barriers	support ongoing healthy behaviours; Project participants have improved health; and, Innovative interventions and new models of public health are identified and shared. **General targeted recipient groups** Funded projects must be led by or developed in close collaboration with Black Canadian community groups, not-for-profit organizations, and/or researchers

			to mental health.	
3-year plan for Healthy Early Years – Official Languages in Minority Communities	Result 1.1: Canadians have improved physical and mental health. Linked to Health Promotion	Start Date: 2018 – ongoing. **$1.890.000**	**Purpose and Objectives:** This funding will support communities to develop comprehensive, culturally and linguistically appropriate programs to improve the health and development of children (0-6 years) and improve access to early childhood health promotion programming for children and their families living in Official Language Minority Communities (OLMC). It is part of a broader government initiative aimed to strengthen official-language minority communities, improve access to services in both official languages, and promote a bilingual Canada.	**Expected Results** Vulnerable families in Official Language Minority Communities will have access to programs and supports that will allow them to gain the knowledge and skills they need to improve their family health practices; and, As a result of the access to programming in the official language of their choice, vulnerable families in Official Language Minority Communities have improved wellbeing as a result of the access to programming in the official language of their choice. General targeted recipient groups • Not-for-profit voluntary organizations/corporations, unincorporated groups, societies, and coalitions.

Appendix 2: Sample Research Instruments

These research instruments which were appended in the research proposal and approved for use by the York University Ethics Board.

Appendix 2.1 : Introductory Recruitment *Script*

Dear **[Participant's name],**

My name is Morris Komakech, a PhD Candidate in the Health Policy and Equity Studies program at York University. My study examines policymakers' everyday work experiences especially how policymakers interact with concepts of social determinants of health (SDOH). The study scope includes understanding the work done before and during the policy making process. I found gaps in literature which suggests that SDOH concepts may not be influencing policy activities in Canada to the extent seen in other jurisdictions. My study will inquire into your work experiences with these concepts as a policymaker.

I would like to interview you. During my interactions with you, both of us will learn from each other. Most importantly, I will be learning from you through approximately 45-60 minutes of an in-depth interview that I intend to audio-record with your consent. Recording will allow me capture what you will be saying accurate for analysis later. I am also interested in text/documents that relate, organize, direct, guide or shape your work, such as contracts, protocols, agreements, guidelines, routine descriptions, rules, regulations, standards and process descriptions that you may make available. These documents/texts form part of the study.

Most importantly, our conversation will remain confidential, transcripts will be seen only by my supervisor and Thesis Committee on a need-to-see basis. No identifying information will be attributed to you or your transcript in accordance with York University Research Ethics Guidelines.

I sincerely hope you will consider contributing to this project. I have included more information about me and the scope of my study in the attached information letter.

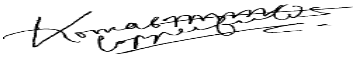
[Or]

[Those Referred by Previous Contacts] Recently, I was referred to you by **[Name]** at [**Organization],** who suggested that you may be willing to share your experiences and knowledge as a [current] or [former] policymaker for the work you [do] did at [particulars]. I am very interested in exploring your experiences in this role, how you did your work, how the work was organized, and what kind of documents or routines governed your everyday work experiences and decisions. Would you, please, consider supporting my research by agreeing to about 60 minutes of an in-depth audio recorded interview? I would be very glad if you could refer me to a person you know with a similar experience of having been a policymaker or contributed directly to policymaking process. I guarantee that our conversation will remain confidential, transcripts will be seen only by my supervisors and Thesis Committee on a need-to-see basis. No identifying

information will be attributed to you or your transcript in accordance with York University Research Ethics Guidelines.

Please feel free to get in touch with me if you have any questions, or if you would like to participate. My email is komakech@yorku.ca. You can also reach me by phone at +1 289 221 2214. Alternatively, you could also reach my supervisor, Prof. Dennis Raphael at this email: draphael@yorku.ca

Thank you so much for your consideration, and I look forward to hearing from you.



Morris Komakech, PhD Candidate
Health Policy and Equity
School of Health Policy and Management
York University.

Appendix 2.2: Research Information Letter

My name is Morris Komakech, a PhD candidate in the Health Policy and Equity studies program at York University. I am writing to you in your capacity as a policymaker going by the description of your position in the organization [X]. I am particularly interested in learning more about your everyday work as a policymaker, how it is organized, and how you make decisions about Social Determinants of Health (SDOH) during the policymaking process.

I have spent time reviewing recent literature suggests that social determinants of health concepts are not filtering through the policymaking process in Canada to the extent they may be doing elsewhere.

There are similar studies in the UK, Australia and some here in Canada which have attempted to explore this issue, but these studies do not take into consideration the lived everyday work experiences of the policymaker. In practical terms, I will be conducting an interview of about 1hr long, at a location of your convenience. I would like to audio record the interview to get accurate data from the interview. During the interview, I will be taking notes and asking you about texts/documents associated with your work, processes, protocols and how your work setting relate locally within departments and with institutions outside of your work setting.

The goals of this project are to generate knowledge and expand our understanding of how social determinants of health concepts are being applied in the policy process. To achieve these goals, I may require your help to link me to other policymakers or individuals that you consider having a similar lived experience of work, as a policymaker or contributing directly to policy making processes.

This research is central to my PhD thesis research, which is a required part of my PhD work. It is an individual student research undertaking which is expected to be innovative and novel in its contribution to health policy and equity field. I will most likely present part of this study at community and academic fora and it will form part of my final report to York University for the award of my doctorate.

This research is being supervised by a Committee of Professors including Prof. Dennis Raphael, Dr. Jessica Vorstermans, an Assistant Professor in the Critical Disability Studies Program at York University, Prof. Dennis M. Pilon, Associate Professor and Undergraduate Program Director at the Department of Political Science and Dr. Marina Morrow, Professor and Chair of the School of Health Policy and Management, all at York University

I hope you will consider participating in this project and share your experiences, ideas and hopes. If you have any questions, please do not hesitate to contact me by email komakech@yorku.ca or by phone at +1289-221-2214. Thank you for your consideration, and I look forward to hearing from you.
Sincerely,

Morris DC Komakech, PhD Candidate

Appendix 2.3: Informed Consent Form

Date: ……..

Study Name: From the Standpoint of Policymakers: An Inquiry into the Policy Making Process to Address Social Determinants of Health

Researcher name:
Morris Komakech (principal investigator) PhD Candidate, Health Policy and Equity studies, York University Toronto, Ontario, Canada Contact: komakech@yorku.ca and Phone number +1XXXXXXXX.

Purpose of the Research:
There is consensus that the public policy that enhance equitable distributions of social, economic, cultural and political resources shapes health positively. The purpose of this study is to understand multiple policy activities and interactions within and between organizations or institutions to discover how concepts of social determinants of health are articulated, conceived, mediated or moderated in the public policymaking process. Through this study, I hope to increase our knowledge and understanding on the daily role of policymakers in informing healthy public policy. The study will explore and discover some social and institutional forces that shape, limit (or enhance) and organize the work of policymakers. The outcome of this study will form part of my doctoral degree in Health Policy and Equity. I will analyze the data and publish journal articles, and I may present parts of my findings at conferences or in class.

What You Will Be Asked to Do in the Research:
As a participant in this study, you will have to consent to participate. After your consent is secured, I will be asking you some questions and you will be at liberty to respond to these questions as you wish. If the question(s) makes you uncomfortable, you could decline to answer and ask to move to the next question. I will also be requesting you for documents or texts that you are comfortable sharing. These documents or texts relate to your role as policymaker. At the end of the interview, which should last about an hour, I may request you to recommend and if possible, introduce me to another person who you are familiar with or know his/her work for me to interview. There is no monetary or any kind of reward for your participating in this study.

Risks and Discomforts:
We do not foresee any risks or discomfort from your participation in the research. However, you may feel uncomfortable when you start thinking about some of the questions that you are asked. For example, you may share information about your work that could be perceived as negative or confidential. If that happens, you can take a break from the interview or, if you want, you can stop the interview completely. If you want to continue to talk about these issues, that's fine too. I will make sure the interview is confidential by choosing a quiet and secured location with a door closed to help minimize any negative impacts of the interview for you

Benefits of the Research and Benefits to You:

There are several great things that may come out of your participating in this study. First, you will be enlightening me on crucial aspects of your everyday work and challenges. You may or may not receive any direct benefit from participation. You might find that it makes you feel glad to talk about some of your experiences, validate your own experiences which you had never verbalized, or even feel inadequate when identifying challenges that you face during your work. The most important thing is that your participation as a professional brings a unique experience that may contribute to a new body of knowledge. The findings may significantly affect the way researchers, academics and policymakers understand institutional processes that mediate health inequities in society.

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 researchers or study staff, or the nature of your relationship with York University either now, or in the future. In the event you withdraw from the study, all associated data collected will be immediately destroyed wherever possible. 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:
The information you provide will fully be kept confidential in line with ethics requirement. Your name will not appear in any report or publication of the research. Original copies of the audio recordings will be destroyed after I have written out all the words, and transcripts will be destroyed, by deletion from the computer and hard drive after 7 years (May 2030).
Written and audio recordings of our conversation and any documents gathered will be securely stored in a password protected computer. I will be the only one who has access to these recordings. I will not include your name in any reports. I may want to write something that you said, word for word in a report because you have made an important point. This is called a "direct quote". I will only use your quote of words exactly like you said them to retain the original meaning. The quotes will not use your name, gender, age or job title so that other people can know what you said but won't know who said it. I may mention the type of work you do so that I can see if what people said in several types of work makes a difference in their perspectives on social determinants of health in the policy making process. So, if you give consent to participate in this interview, you will also be giving consent to use your quotes.

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 me (Morris Komakech) by email at komakech@yorku.ca or by phone at +1289-221-2214. You may also contact my supervisor (Prof. Dennis Raphael) by email at draphael@yorku.ca or by phone at 416-736-2100, ext. 22134.
This research has received ethics review and approval by the Delegated Ethics Review Committee, which is delegated authority to review research ethics protocols by the Human Participants Review Sub-Committee, York University's Ethics Review Board, and conforms to the standards of the Canadian Tri-Council Research Ethics guidelines. If you have any questions about this process, or about your rights as a participant in the study, please contact the Sr. Manager & Policy Advisor for the Office of Research Ethics, 5th Floor, Kaneff Tower, York University (telephone 416-736-5914 or e-mail ore@yorku.ca).

Legal Rights and Signatures:

I…….. consent to participate in the study: **From the Standpoint of Policymakers: An Inquiry into the Policy Making Process to Address Social Determinants of Health** conducted by Morris Komakech. I have understood the nature of this project and wish to participate. I am not waiving any of my legal rights by signing this form. My signature below indicates my consent.

Signature _____ **Date** _____
Participant

Signature _____ **Date** _____
Principal Investigator

Additional consent (where applicable)

1. **Audio recording**

☐ I consent to the audio-recording of my interview(s).

Signature: Date:

_____ _____
Participant: (Name)

Appendix 2.4: Questionnaire Guide

Background Information

Canada has a long history of contributing to the promotion of health equity through action on the social determinants of health. This line of thinking considers how the quality and equitable distribution of resources for health depend on policies made by governments and public health authorities. Some examples of this thinking are the World Health Organization's Commission on Social Determinants of Health, the Canadian Senate Reports on Population Health and recommendations from works by Health Council of Canada, among others. The means by which policy shapes health are the social determinants of health such as income, employment, and food and housing security.

The purpose of this interview is to try to understand from your standpoint how these concepts have filtered through policymaking in Canada. My interest is in understanding the various influences that facilitate or inhibit social determinants of health from being the focus of public discussion in regard to health outcomes. For each of the topics that follow, if you can point me to or provide documents such as mission statements, strategic plans, evaluation reports, or guidelines and protocols of your agency that illuminate these issues, it would be helpful.

1. What roles have you played in influencing public policy?
   ***Probes**: I will ask you about your everyday work activities and decisions*
   a. How did you come to work in health policy (directly or remotely)?
   b. How do you think about the term "health equity", before and now?
   c. How do you think about the term social determinants of health?
   d. How do you think about health policy action on health equity?
   e. What would policy action that promote health equity look like? What would be its main components?
   f. What were some of the key features of your work, what were your responsibilities as it related to both SDOH and Health Equity?
   g. How was the social determinants of health concept part of your everyday work?
2. What values guided your institution's approaches to promoting health equity?
   ***Probes:** Establishing institutional context*
   a. What are some institutional values and beliefs concerning health equity that provided a context for your work?
   b. What are some of your institution's primary focus regarding promoting health equity?
   c. How do you evaluate the potential impact of the policies that you made (or contributed to) on the population? Did you have a mechanism that provided you (or your organizations) with feedback on their impacts?
3. What activities form part of your policymaking work?
   ***Probes**: I will ask you some questions about the Policy making process*
   a. What was your role or contribution in the policy making process?
   b. What were the common understandings of social determinants of health in your work?

c. Can you tell me more about your work with SDOH during the policymaking process? How does it begin and end? (What were the conflicting or acceptable views on SDOH?)
d. What were you expected to deliver, and who receives, uses or reviews your deliverables as work?
e. How did you collaborate with other departments when developing (or considering) a policy position?
f. How do these departments approach discussions on social determinants of health?
g. What are some of the rules, protocols, (implicit or explicit) traditions around policy making related to promoting health equity in this institution? Could you refer to specific documents?

4. What supports and challenges did you get in your work in promoting health equity using SDOH concepts?

***Probes**: Locating the problematic*

a. What were some activities or opportunities that supports SDOH that you have recommended, and considered but not taken?
b. What are some of the reasons you think these activities or opportunities on SDOH were important at the time or even now?
c. What were some of the barriers to you implementing these activities or taking advantage of these opportunities on SDOH?
d. How have such barriers been addressed or not addressed in the past or now?
e. Do you see the outcome of the policies that you make?

5. What have been some of the specific influences upon your coming to think about the social determinants of health?

***Probes**: External Sector influence on SDOH concepts.*

a. How do external interests influence your work on social determinants of health, and could you identify these some of these external influences?
b. Were these external influences expected? How do you balance these interests with public interests?
c. Are there rules or standards of practice in your work that helps you mediate these outside interests?
d. How do you identify business/corporate or political interest in your work when social determinants of health are discussed?
e. Who normally has the final say in the chain of decision-making during policy process?

***Probes:** Explicating roles of Civil Society, labour, corporate. and political ideology influence*

a. What roles have you seen civil society organizations, such as anti-poverty groups, labour union, housing and income equality groups, playing over health equity related policy discussions?
b. How were you taking these interests into consideration?
c. How do you mediate between evidence from practice, pressures from external influences and political environment during your work as a policymaker?
d. In the time you have held your position, have you recognized how policies have improved or declined in its focus on SDOH?

6. Revisiting the Social Determinants of Health Concept

There are differing approaches to thinking about the social determinants of health. Some focus on identifying social determinants of health such as income, employment and working conditions, and housing and food security, among others, and assume that policymaking will take note of these issues.

Some go further and identify the specific health and social policies or public policy in general that shape the quality and equitable distribution of these social determinants. These can include legislation concerning wage levels, social assistance levels, and housing availability and even the nature of taxation and redistribution.

Finally, others are concerned with how the power and influence of differing sectors such as the corporate and business or organized labour sector influence public policymaking in Canada. As one example, it is difficult to raise minimum wages if a particular sector strongly opposed such action.

Where do you think you fall along this continuum both in your personal beliefs and your range of potential action in your previous policymaking role?

In light of this discussion, would you like to revisit earlier thoughts on the influence of societal sectors such as the business and corporate sectors, the organized labour sectors, and civil society groups?

How do you see the future of public policy in the service of promoting health equity through action on the social determinants of health playing out? In general? In relation to your past activities?

I thank you very much for being patient and engaging during this interview. It means a lot to the field of health policy and Equity.

End.

Appendix 2.5: Sample Request to Interview Letter

Generic Request to Interview

Dear …….

YORK
UNIVERSITÉ
UNIVERSITY

FACULTY of Health
School of Health Policy and Management

4700 KEELE ST
TORONTO ON
CANADA M3J 1P3
T : 416 736-2100
EXT 22134

Date :

My name is Morris Komakech, a PhD Candidate in the Health Policy and Equity Studies program at York University. My study examines a policymakers' everyday work experiences especially how policymakers interact with concepts of social determinants of health (SDOH). The study's scope includes understanding the work done before and during the policy making process. I found gaps in literature which suggests that SDOH concepts may not be influencing policy activities in Canada as expected and to the extent seen in other jurisdictions. My study will inquire into your work experiences with these concepts as a policymaker.

I would like to interview you to obtain insights into your experiences. During my interactions with you, both of us will learn from each other. Most importantly, I will be learning from you through approximately 60 minutes of an in-depth interview that I intend to audio-record with your consent. Recording will allow me capture what you will be saying accurately for a later analysis. I am also interested in text/documents that relate to, organize, direct, guide or shape your work, such as contracts, protocols, agreements, guidelines, routine descriptions, rules, regulations, standards and process descriptions that you may make available. These documents/texts form part of my study to understand your work better.

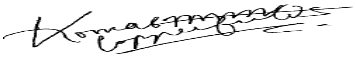
Most importantly, our conversation will remain confidential, transcripts will be seen only by my supervisor and Thesis Committee on a need-to-see basis. No identifying information will be attributed to you or your transcript in accordance with York University Research Ethics Guidelines. I sincerely hope you will consider contributing to this project. I have included more information about me and the scope of my study in the attached information letter.

Please feel free to get in touch with me if you have any questions, or if you would like to participate. My email is komakech@yorku.ca. You can also reach me by phone at

+1 289 221 2214. Alternatively, you could also reach my supervisor, Prof. Dennis Raphael at this email: draphael@yorku.ca

Thank you so much for your consideration, and I look forward to hearing from you.

Sincerely,



Morris Komakech, PhD Candidate
Health Policy and Equity
School of Health Policy and Management
York University.