The Vital Politics of Gentrification

Governing *Life* in Urban Canada into the 21st Century

Jessica Parish

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Abstract

This dissertation is about the vital politics of gentrification. The vital politics of gentrification is a politics of space that places the question of the vital characteristics of people and places at its very core. The dissertation argues that this vital politics is evident in the alignment between the 21st century proliferation of new forms of health and wellness consumption in gentrifying urban neighbourhoods (i.e. yoga studios, day spas, and juice bars) and broader shifts in how governing mentalities understand the relationship between health and urban space. The concept of the vital politics of gentrification is offered as a critique of normalized and commonsensical modes of thinking and acting towards health in the contemporary moment.

This critique has two main parts. The first seeks to understand contemporary spatial problematizations of health in light of those that came before. In particular, the birth and normalization of forms of knowledge-power that problematize "health" as socially and environmentally determined (that is, determined by the social and physical characteristics of where we "live work and play") has had major impacts in recent decades on the theory and practice of governing urban space and urban populations. To understand the emergence of this form of political rationality the dissertation pursues a genealogy of the relationship between space and how health is conceptualized and problematized since the "golden age" of public health in early 20th century Canada.

The second part documents how "health" and "vitality" have become constitutive aspects of material struggles to define, enact, and inhabit space in the West Toronto neighbourhood of Parkdale. Parkdale is an important case study because it is a neighbourhood where significant levels of material deprivation exist "cheek by jowl" with an emergent proliferation of forms of elite heath care consumption. Against the backdrop of the changing spatial problematizations of health, I conclude that that the actions of diverse agents have converged to produce Parkdale as a "healthified" space, a space in which forms of valuation and belonging are actualized and enacted through the power to lay claim to "health." I further conclude that this raises distinct challenges for thinking about justice in the 21st century.

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I will put a very simple proposition to you: namely that today, all politics is about real estate.

– Fredric Jameson (2003)

… in this great preoccupation about the way to govern and the search for the ways to govern, we identify a perpetual question which would be: 'how not to be governed like that, by that, in the name of those principles, with such and such an objective in mind and by means of such procedures, not like that, not for that, not by them'

– Michel Foucault (1997)

Chapter 1
Introduction: Health, Gentrification, and Biopolitics

> One must ask what knowledge of the body and life processes is assumed to be socially relevant and, by contrast, what alternative interpretations are devalued or marginalized. What scientific experts and disciplines have legitimate authority to tell the truth about life, health or a given population? In what vocabulary are processes of life described measured, evaluated and criticized?
>
> –Thomas Lemke, 2011, *Bio-Politics*

1. Statement of Problem

This dissertation is about the vital politics of gentrification. The vital politics of gentrification highlights the ways in which contemporary forms of urban governance place the question of the biological existence and vitality of human individuals and populations at their core. Accordingly, contemporary urban transformations take place through a field of complex, and at times contradictory, discourses and practices pertaining to the health and vitality of human beings and the range of presumed threats to and strategies for its optimization.

"Gentrification" is usually understood as a struggle over land, housing, and affordability—in short, as an economic struggle (Marcuse, 1985; Slater, 2011; Smith, 1996). It is also a symbolic and political struggle for representation and belonging (Keatinge & Martin, 2015; Kern, 2015a; Masuda et al., 2012; Mazer & Rankin, 2011). I argue here that gentrification, as a form of struggle over urban space, is increasingly taking the character of a "politics of life itself" (Rose, 2001; 2007). In other words, the process of gentrification is becoming entangled with forms of politics premised on the modification of biological existence, that is oriented towards the mitigation of susceptibility to disease and the optimization of life (Rose, 2007). This is happening for reasons that cannot be explained with recourse or reference only to the spheres of economics and politics, as narrowly conceived. In response to new forms of knowledge in fields such as public health and

epidemiology, the vitality of human beings is placed at the centre of urban forms of governance by forms of knowledge that articulate the risks and opportunities for "health" to specific locales in the urban milieu. These forms of knowledge take shape through reports, maps, histograms, benchmarks, indices, and the like, and they are produced and disseminated by governments, hospitals, private research foundations, public universities, in academic journals, on organizational websites, and in mainstream media platforms. As such, they constitute a normalized form of knowledge, which brings urban space into visibility in novel ways.

Scholars have previously noted that gentrification is frequently described by commentators in ideological language emphasizing life, youth, and vitality with words such as "revitalization," "rejuvenation," and "renaissance" figuring prominently in both government and commercial efforts to package and build consensus around this form of urban change (Keatinge & Martin, 2015; Kern, 2010, 2015a; Slater, 2005; Smith, 1996). The vital politics of gentrification extends these observations by calling attention to the extent to which contemporary practices of urban governance place the question of the vitality of human life at their very core. In so doing, the vital politics of gentrification also builds on and extends the work of political scientist Karen Murray (2015), whose critical intervention into the study of gentrification, demonstrated how an analytic of biopower opens up the possibility of assessing "value-generating dynamics" beyond land and property markets "at the level of biological existence" (p. 279). As Murray has demonstrated, removal and displacement are but one of many spatial tactics available to biopolitical governance.

The concept of vital politics therefore draws on the broader concept of biopolitics, as it was developed by Michel Foucault, and extended by Thomas Lemke (2011) and Paul Rabinow and Nikolas Rose (2006). As articulated by Foucault, biopolitics is an approach to

political analysis that foregrounds the "relational and historical character" of "life" and "politics" (Lemke, 2011, p. 4). The concept embraces

> all the specific strategies and contestations over problematizations of collective human vitality, morbidity and mortality; over the forms of knowledge, regimes of authority, and practices of intervention that are desirable, legitimate and efficacious. (Rabinow & Rose, 2006, p. 197)[1]

Following Lemke, this dissertation is organized around two primary research questions. First, what forms of living and being are promoted in contemporary health discourses and practices in Toronto? Second, how are these contemporary discourses and practices are taken up, and/or contested in particular places, lives, and bodies? These questions allow us to shift the lens on how health is typically talked about as a field of government and power. They also allow us to disrupt the unidirectional correlation implied by the popular policy language that frames environment as a social *determinant* of health. Thus, in addition to asking how the environment determines health, we should also ask 1) through which processes and mechanisms do forms of knowledge about health shape the materialities of places and spaces? and 2) how are bodies and subjects constituted in and through these spaces and the forms of knowledge effected?

In the context of this project, "health" is understood as a complex and contested concept that is given meaning through forms of knowledge and through the practices tied to those forms of knowledge. At the dawn of the new millennium, risks and opportunities for "health" came to be understood increasingly in local terms, and as inextricably linked to the character of one's neighbourhood (CIHI, 2006; Cohn, Farley, & Mason, 2003; Pickett & Pearl, 2001). An individual's current and future health status came to be seen as measureable in terms of how and where they "learn, live and work" (CIHI, 2006). As such, a whole range

[1] Originally published in 2006, the essay "Biopower Today" (Rabinow & Rose, 2006) was recently reprinted in Cisney and Morar's (2016) edited volume, *Biopower: Foucault and Beyond.*

of presumed health-promoting or health-detracting aspects of contemporary neighbourhoods—from tree cover, to crime, to the number of grocery stores, or the number of breast cancer screenings—were gathered, benchmarked, and indexed such that individual neighbourhoods could be compared and assessed as "good" or "bad," and "healthy" or "unhealthy" places to live (Canadian Institute of Planners, 2016; Martin Prosperity Institute, 2013, 2015; St. Michaels Hospital, 2014; Vancouver Magazine, 2016). How did we come to think of health in this way? What are the effects of this mode of knowing and acting on "health"? And what, if anything, does the contemporary will to audit, rank, and order have to do with changing material practices around health?[2]

This trend in the knowledge and practice of health has taken shape contemporaneously with both the responsibilization of health falling under the public health logic of promotion (Crawford, 1980; Lavernce & Lozanski, 2014; Lowenberg & Davis, 1994; Lupton, 1995), and the mainstreaming of corporeal practices associated with complementary and alternative medicine (CAMs) (Health Canada, 2003; Tovey, Easthope, & Adams, 2004). The dissertation argues that, pursuant to these shifts, which emphasize the biological existence of people as a key political and governmental field, healthified spaces are emerging. Neo-Foucaultian public health scholar and critic Carolyn Fusco (2006, 2007) developed the concept of the healthification of space. Fusco defined healthification as "the continuous deployment of a broad range of specialized techniques and technologies… that work together to produce 'healthified' spaces (and subjectivities)" (2007, p. 59). Such measures may include "policy and educational initiatives, architectural arrangements, urban planning,

[2] Rose (1999) cites four types of "political numbers" used in advanced liberal societies, one of which is the numbers which "make government both possible and judgeable" Ranking and benchmarking are precisely the kinds of numbers that allow government officials, as well as businesses, charities, and individuals, to make ostensibly "scientific," "transparent," and "neutral" judgments about which neighbourhoods to invest in and how.

measures of public order, health and safety regulations, self and other observations" (p. 59). The specific dynamics of current processes of intensified gentrification in Parkdale cannot be adequately understood without attention to the unfolding of these processes of healthification.

The emerging emphasis on the relationship between neighbourhoods and "health" calls for an analysis of how forms of expert knowledge pertaining to the relationship between health, wellbeing, and space are implicated in processes of neighbourhood change, such as gentrification. My research focus in this regard is the gentrifying West Toronto neighbourhoods of Parkdale. Therefore, against the backdrop of the heightened emphasis on neighbourhood rankings and the place of health and wellness within these rankings, this dissertation begins with the observation that commercial Complimentary and Alternative Medicine providers have an uneven distribution in the urban landscape of Parkdale. CAMs include yoga and pilates services; naturopathy; chiropractors; massage therapy; acupuncture and traditional Chinese medicine; nutritionists and healthy eating lifestyle consultants; and the use of herbs, supplements, and functional foods, to name a few of the most popular (see Achilles et al., 1999; Barcan, 2011, 2008; Collyer 2004; Tovey, Easthope, & Adams, 2004; Crawford, 1980; Eisenberg et al., 1993; Ross, 2012). CAMs may be offered in a practice setting in which a single modality is emphasized, or, more commonly, as in the case presented here, in multidisciplinary settings such as holistic care clinics, day spas, wellness centres, interdisciplinary yoga studios, and so forth.

The growth of CAMs in Parkdale needs to be understood in relation to the proliferation of expert knowledge pertaining to the social determinants of health and health promotion. Both concepts emerged and rose to prominence in the period between the 1970s and 1990s "in response to the recognition that living conditions are the primary

determinants of health in nations such as Canada" (Bryant, 2009, p. 47). However, there is no single means of conceptualizing "living conditions," and experts take this up in vastly different ways at different times and in different institutional contexts (Bryant, p. 48). Viewed from the vantage of these simultaneous but not necessarily causally connected moments, "Parkdale" can be viewed as a complex terrain of shifting knowledge about life, health, and bodies.

Alternative health care, once thought to be a fringe form of complementary preventative measures, are now mainstreamed in an emergent political economy of urban governance. This new political economy is shaping new class lines in the uneven distribution of and access to health provisions that are considered central to health and wellness in Canada at the dawn of the 21st century. CAMs are increasingly mainstream aspects of how people reproduce themselves as normatively "healthy citizens" and "good consumers" in Canada and other advanced industrial democracies (Johnston, 2004; see also Achilles et. al., 1999; Crawford, 1980; Eisenberg et al., 1993). These practices also normalize emergent and variegated forms of, and access to, health provisions considered central to health and wellness. As such, their reemergence in particular places is a testament to the historical contingency and geographic specificity of "health" as a concept, a practice, and a state of being.

These dynamics are subtly reshaping the very meaning of core concepts in the health literature, including, and especially, critical and political economy approaches to health and health care. Concepts such as access, necessity, class, and universality appear in a new light after these once-alternative services became mainstream *for some people*. Similarly, the trend towards evaluating the quality or "goodness" of a place according to what is understood to

be its quantifiable health-promoting or health-detracting characteristics bears witness to shifting conceptions of the good life, how this can be obtained, and by whom.

In order to understand these biopolitical modes of contemporary urban governance and the process of gentrification within them, the dissertation looks at the contemporary moment through a genealogy of health-governing mentalities in Canada. I trace a broad trajectory across two distinct shifts in the dominant political rationalities that inform the governance of health. First, in the early 20th century public interest in "health" was closely tied to the management of infectious disease through forms of local governance. However, after the Second World War, health became a public matter that was territorialized across national space as an important piece of nationalist ambition for territorial integration (Boychuk, 2008) and the shift from classic to welfare liberal modes of governing. By the 1980s and 1990s expert discourses in health were increasingly pointing to the importance of local milieu as key sites where health have been shaped outside of or "beyond" formal health care, in ways that opened the door for the present emphasis on neighbourhoods as key "determinants" of health. These changes have been bound up with shifting conceptions of risk and security and their urban geography, as well as shifting techniques for their assessment and management. This, in turn had implications for how risks have been shared and distributed, and for the very constitution of populations vis-à-vis "risk."

This methodological approach takes its cue from the genealogy of modern European states introduced by Foucault in the lectures he gave at the college de France in the late 1970s (Foucault, 2003, 2007; Valverde, 2007). This project has been extended in various ways and without a view to "completion" by scholars such as Lemke (2001), Marianna Valverde (2007), and William Walters (2000). What these writers have in common is a methodological orientation to the role of knowledge-power in shaping forms of governance,

and a certain adherence to Foucault's insight that modern forms of governing are those which place the question of humans as living creatures and as a species at their core.

For Foucault and those he influenced, the body and the governmental subject are historical entities. Thus, he sought to write a history of the embodied subject as a means of confronting the question: "what kind of beings are we *now*?" (Foucault, 1997). To do this he undertook what he called a genealogy of the subject. Genealogy differs from other approaches to history in that it aims to present neither a comprehensive picture of a particular time and place in the past, cut off from all those processes and events which succeeded it, nor "a history of the past in terms of the present" (Foucault, 1977). Rather, genealogy seeks to write a history of the present. In order to do so the genealogist begins from a diagnosis of her contemporary, and from this diagnosis seeks and endeavours to understand those events that have allowed for or made possible the emergence of the present in its particularity. Genealogy asks: how did *this* present come to be, and not some other one (Foucault, 1998a)?

In a similar fashion, but with a much humbler scope, the present project seeks to understand the specificity of contemporary modes or "practices" for conceptualizing the relationship between health and urban space—of which the "social determinants of health" is a key instance. I do so by pursuing a genealogy of the spatial imagination in expert discourses about health in Canada since the early 20th century. What happens to the social determinants of health if we treat health not as a universal objective truth, but as an historically specific and contingent form of knowledge/power which is itself implicated in "making up" (Hacking, 2016) the people and places about which it presumes to speak? A neo-Foucaultian lens is useful in looking at practices as "places where what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and

interconnect" (Foucault, 2000a, p. 225). Practices are neither theories nor ideologies, and thus one must try to understand their own "regularities, logic, strategy, self evidence [and/or] 'reason' as it shows up both in the act of defining what it to be known and what is to be done (Foucault, 2000a, p. 225).

The research perspective is based on an understanding that public policy, as a mode of governance, is not merely a "reactive" domain, but rather a productive one which constitutes the subjects and objects of governing through the process of problematization (Murray, 2007; Osborne, 1997). Further, from this perspective differences and shifts between classic to welfare to advanced forms of liberalism are not understood in state-centric terms. This is not to say that the state is not relevant to political analysis (Murray, 2004b, 2007). However, neo-Foucaultian scholars emphasize forms of knowledge-power that organize the "conduct of conduct" (Foucault, 2007; Isin, 2000; Lemke, 2000). Such forms of knowledge-power may be located within official institutions of power, but they may also emanate from families, communities, professions, philanthropic organizations, and so forth (Isin, 2000; Murray, 2007). This way of thinking about politics and government took on a distinct significance beginning in the latter days of the 20th century, as advanced liberal modes of governing (Rose, 1999) put increasing emphasis on the role of families, individuals, and communities in their own social reproduction (Isin, 2000; Murray, 2007). Further, in this view, the crux of the difference between forms of liberalism is not adequately captured by the notion of ideology, or in binary oppositions between "collectivizing" (welfarist) and "individualizing" (neoliberal) forms (Foucault, 2000b). Rather, liberal forms of biopower operate through, and articulate connections between, the poles of individual and collective but in different ways and at different times (Lemke, 2011; Rose, 1996; Walters, 2000). As Rose (1996) has schematically suggested, classic liberalism governs through the social,

welfare liberalism governs through the state, and advanced liberalism governs through communities. Each form of governing produces different types of collectivity and relations between individuals and populations.

2. Discussion of the Literature

There are three groups of literature that this project seeks to draw together and extend. Each contributes an important perspective, but also has its own limitations. The first is the critical political economy literature that takes up the question of the impact of "neoliberalism" on health. The second explores the phenomenon of gentrification, its displacement effects, and their relationship to questions of health, environment, and embodiment. The third, a neo-Foucaultian body of work, adds the analytical tools of genealogy and biopower to questions of space, health, and bodies. This third body of literature extends the political economy analyses of the former two by highlighting "health" as a mobile field of governance and knowledge-power that is central to the biopolitics of space and subjectivity.

2.1 Critical Political Economy: Health in Crisis

Crisis is a key theme in political economy and sociological approaches to the study of health. For political economists, the period we are currently living in is a neoliberal one, defined by structural shifts in the organization of the economy away from Keynesianism and the post-War Fordist regime of accumulation (Connell, 2010; Harvey, 2005; Smith, 1996).[3] In the face of declining profitability for the capitalist class, neoliberalism emerges as an ideological program to restructure the balance of power in favour of a global ruling class, through

[3] Characteristic features include, for example, full employment, premised on a single breadwinner model; expanded public provision of social services, including insurance against sickness and unemployment; counter-cyclical government spending; and a relatively permissive attitude towards organized labour.

financial deregulation and the progressive commodification of ever more spheres of social life:

> 'Neoliberalism' broadly means the agenda of economic and social transformation under the sign of the free market that has come to dominate global politics in the last quarter century. It also means the institutional arrangements to implement this project that have been installed. Step by step, in every society under neoliberal control." (Connell, 2010, pp. 22-23)

Changes in the overall regime of accumulation in the post-1970 era are therefore seen to precipitate changes in the "welfare subsystem" (Walters, 2000), including the formal health care sector, and modes of social reproduction (Bakker & Silvey, 2008). These changes occurred as states began to "roll back" forms of social provision and labour and environmental protections, (Peck & Tickell, 2002), thus facilitating the extension of market relations into new spheres of everyday life (Bakker & Silvey, 2008; Braedley & Luxton, 2010). In this view, the shift from classic to welfare to neoliberal regimes is conceptualized in terms of the growth and subsequent contraction of the state: in classical liberalism we find a narrow conception of the public realm and the role of the state in social life (Murray, 2004b).

For complex historical and economic reasons, the state and the public realm underwent an expansion culminating in the post-War period as the Welfare state as the institutional expression of Fordist class compromise (Harvey, 2005). In this period the state took on an historically unprecedented scale of fiscal and administrative responsibility for measures of social provisioning for citizens: the expansion of public education, insurance against the risks of unemployment, old age and sickness (Harvey, 2005). However, in the neoliberal post-1970s period, the state increasingly divested itself from responsibility (especially financial responsibility) for such measures, thereby pushing or downloading such measures back onto private individuals, families, and/or less powerful levels of government (Bakker & Silvey, 2008; Connell, 2010; Harvey, 2005; Braedley & Luxton, 2010; Bezanson,

2010; Peck & Tickell, 2002). The neoliberal period is therefore associated with various forms of crisis (Harvey, 2005), including a crisis in health and health care (Armstrong & Armstrong, 2010; Benatar, Gill & Bakker, 2011; Leys, 2010).

Three key problematics within this literature are illustrative of the broad theme. The first deals with the phenomenon of privatization and the undermining of public ownership and administration of health insurance programs and health-related infrastructure (Armstrong & Armstrong, 2010; Whiteside, 2011, 2015). The second addresses the impacts of neoliberal policies on forms of paid and unpaid labour in health care provision (Armstrong & Armstrong, 2010; Braedley, 2010; Cohen & Cohen, 2006). The third emphasizes the negative effects of neoliberalism on the social determinants of health (Bryant, 2009; Coburn, 1999, 2010; Mikkonen & Raphael, 2010; Navarro, 2009).

2.1.1 Privatization

The problem of privatization under neoliberal forms of rule is many faceted, and the term itself can designate one or more of several interrelated dynamics (LeDuc Browne, 2000). Broadly, privatization refers to the reduction of state (i.e. public) responsibilities and commitments to forms of collective provisioning. In Ontario, the pursuit of public-private partnerships in hospital (and other areas of) infrastructure was a key strategy that emerged in the 1990s under the Harris administration, and has continued to gather momentum to date (LeDuc Browne, 2000; Palley, Pomey, & Adams, 2012; Whiteside, 2015). Other strategies in health care privatization include "the introduction of private-sector business strategies and management ideologies into the public health care system" (LeDuc Browne, 2000; see also Whiteside, 2015); the contracting out of "hotel" or "ancillary" services such as laundry and food services in hospitals (Armstrong & Armstrong, 2010); reductions in spending and rationing of services, including the delisting of formerly insured services (in Ontario,

chiropractic and non-hospital-based physiotherapy were both delisted under the McGuinty Liberals) (Palley, Pomey, & Adams, 2012); and, finally, strategies of for shifting costs from "the public purse to the individual household" (LeDuc Browne, 2000).

"Privatization" is therefore a particularly fraught area of study in health care, because of the sheer complexity of health care and the multiple boundaries between public and private contained therein (LeDuc Browne, 2000). This theme has been especially important for political economy because, on the one hand, privatization in its various forms is seen to be the "spearhead of the neoliberal assault on social citizenship" in Canada (LeDuc Browne, 2000), and, on the other hand, because health *care* enjoys special status, insofar as it is understood as "Canada's most cherished social program" (LeDuc Browne, 2000: 1). It is, therefore, a central program for mitigating the socioeconomic inequalities of capitalism, by transferring resources from the "healthy and wealthy" to the "unhealthy and unwealthy" (Evans, 2008).

2.1.2 Social Reproduction

Social reproduction "refers to both biological reproduction of the species (including its ecological framework) and ongoing reproduction of the commodity labour power" (Bakker & Silvey, 2008, p. 2). Social reproduction therefore understands the forms of work, as well as the social and institutional arrangements that make the reproduction of capitalist social relations possible, to be of central significance. Included in this are forms of care work and institutions such as health care and education that allow for the socialization of risk (Bakker & Silvey, 2008). Working within this framework, feminist political economy has extended the analyses of neoliberalism and privatization to include the effects of broad macroeconomic processes on the life and labour of historically marginalized groups such as women and people of colour in ways that exacerbate the racialization and feminization of poverty,

violence, and insecurity (Agathangelou, 2004; Braedley & Luxton, 2010; Ewig, 2008; Pyshchulina; 2008; Silvey, 2008; Thomas; 2010).

One subset of this literature has paid particular attention to the impact of neoliberal policies on forms of paid health and care work (i.e. nursing, food, and laundry services) or as unpaid work in the home or through voluntary organizations (Armstrong & Armstrong, 2010; Cohen & Cohen, 2006; Braedley & Luxton, 2010; Valiani, 2012). Neoliberalism exacerbates the existing tendency of capitalist patriarchy to undervalue female and feminized forms of labour and forms of caring labour based on the assumption that this labour is very similar to the "natural" work done by women in the domestic sphere (Cohen & Cohen, 2006). For example, with respect to nursing, feminist political economy has highlighted the ways in which health care costs in Canada have been controlled by supplanting secure, well-paid jobs for citizens and permanent migrants with lower paid, insecure, and temporary migrant labour from the Global South (especially the Philippines) (Valiani, 2012). Similarly, the contracting out of "hotel services" has also meant that formerly public sector work has been shifted to the private sector, with the result that jobs have become lower paid and more precarious (Armstrong & Armstrong, 2010; Cohen & Cohen, 2006). Belt tightening in the formal heath care system has also had the effect of placing additional burdens on care work and care workers in the home and in not-for-profit sectors, as patients are released from hospital sooner or more care is expected to be provided in the home, frequently by female relatives of the sick or infirm (Armstrong & Armstrong, 2010). Forms of labour have also been inadvertently shifted to other public services, such as firefighting, which is neither conventionally understood as site of caring labour, nor is it particularly well equipped to deal with the type of chronic care issues that increasingly fall through the cracks of neoliberal restructuring (Braedley, 2010).

2.1.3 The Social Determinants of Health

The critical political economy literature that has the most direct bearing on the present project is that which addresses the impact of neoliberalism on the social determinants of health. Looking at the issue through a political economy lens, "health" in capitalist societies is a product of social class relations (Armstrong & Armstrong, 2010; Bryant, 2009; Coburn, 2016; Collyer, 2016; Navarro, 2009, 2004). Critical political economists therefore emphasize "upstream" determinants of health, especially capitalism, as a form of social and economic organization that systematically produces unequal distributions of resources within and across national economies (i.e. Bryant, 2009; Coburn, 2010, 2016). While the formal health care sector is seen as an important public asset (Le Duc Browne, 2000 Whiteside, 2015) and the forms of labour that make it possible are also of particular interest (Armstrong & Armstrong, 2010; Luxton & Braedley, 2010), the core problematic of this literature is the observation that the health and longevity of the population are shaped by myriad facets of social life outside of the formal health care system. Thus poor health outcomes, as assessed by population-level indicators such as life expectancy and infant mortality, correlate not only with class differences in an absolute sense, but also with large material disparities between social classes (Coburn, 2010; Leys, 2010; Navarro, 2009, 2004; Raphael, 2002).

In contrast to positivist biomedical paradigms which seek to understand causal relationships between disease pathogens, host bodies, and expressed symptoms, political economy asks questions about how class relations, as relations of political and economic power, shape differential health outcomes for different people and communities (Bryant, 2009; Collyer, 2016). Here, medicine and "medical dominance" are understood to be the historical developments that take place within the broader development of capitalism and its distinct mode of production, forms of private property ownership, and so forth (Coburn,

1999). The development of national health care systems is a form of class compromise that mitigates the worst excesses of capitalism, but stops short of truly socialized health care (Armstrong & Armstrong, 2010) and, even becomes a major constitutive dimension of the production of inequality and capitalist fiscal crises (Navarro, 1976, 1977). The shift from welfare liberal to neoliberal regimes of accumulation places emphasis on increased individual, rather than collective, forms of provisioning, thereby exacerbating social and economic inequality, deepening the crisis in health (Coburn, 2010; Navarro, 2006, 2009).

This body of work shares with the broader political economy literature an understanding of neoliberalism as an ideological program, or as a class project to restructure the balance of power in favour of a global ruling class, through financial deregulation and the progressive commodification of ever more spheres of social life. A major focus of this research has been to document the negative effects of macroeconomic policies associated with neoliberalism on the health outcomes of global populations (Bryant, 2009; Coburn, 2010; Ley, 2010; Mikkonen & Raphael, 2010; Navarro, 2009). Accordingly, these writers use national-level data on the health status of populations and macro-economic data to call attention to disparities within and between states globally. As medical sociologist David Coburn argues, the neoliberal policies of Thatcher and Regan in particular led to dramatic growth of income inequality in the UK and US, respectively (2010, pp. 46-47). Thus, "[n]ot surprisingly, despite economic expansion in the 1970s and 80s health inequalities increased" (p. 47). Similarly, according to Juha Mikkonen and Dennis Raphael, Canada, when compared to other nations, also has a poor track record in addressing the social determinants of health across people's lifespans: "income inequality and poverty rates are growing and are among the highest of wealthy developed nations. Canadian spending in support of families, persons

with disabilities, older Canadians, and employment training is also among the lowest of these same wealthy developed nations" (2010, p. 8).

Broadly speaking, the view that health is shaped by factors outside of the formal health care system is shared with mainstream research in fields such as public policy, public health, and epidemiology (see Bryant, 2009; Evans & Stoddart, 1994). However, political economists are critical of the way in which the discourse on the social determinants of health has been taken up in mainstream policy and research, a difference that hinges on the distinction between socio-economic status and class. For example, according to one study cited by the Canadian Institutes of Health Research in making the case for neighbourhoods as a key health policy object:

> Neighborhoods of persons of lower SES [socio-economic status] tend to have higher rates of physical disorder and deterioration and also are characterized by social disorder. They also are more likely to have features that directly promote unhealthier lifestyles, such as a higher density of alcohol outlets and a lack of or higher prices for healthy foods at grocery stores. (Cohn, Farley, & Mason, 2003, p. 1632)

Thus, the authors conclude, "When it has been studied, the neighborhood of residence is an important predictor of mortality" (p. 1632). Coburn (2010) argues that while it is empirically true that people of higher socio-economic status (SES) live longer than those with low SES, the category itself is problematic because it represents "*a mere ranking of people* according to income, educational attainment or occupational position" (p. 44, emphasis added). While health is correlated to the factors listed above, socio-economic status as a category calls out for further explanation: why does this form of stratification happen in the first place? Thus, argues Coburn, "SES is itself a result of class forces…. The nature of the capitalist class structure, and the outcome of class struggles, determine the extent and type of socio-economic inequalities in a given society and socioeconomic inequalities in turn shape the pattern of health – and of health care" (2010, p. 44). In other words, SES and income

inequality are just proxies for the various forms of social inequality that impact people's health and wellbeing. And, while socio-economic status may *reflect* differences in the extent to which "different regions or nations provide for the wellbeing of their populations," it cannot *explain* them (p. 46). Thus, the most basic or fundamental determinant of health for these writers is the political and economic structure of the capitalist state: "A broader conception of the causal sequence produces a picture of class related structural factors which produce both elongated SES hierarchies and worse average levels of health" (p. 46).

Notwithstanding the major contributions of these aforementioned examples, there are three key limitations. First, the dynamics of these transformations are seen in terms of the needs and movements of capital, and an attendant understanding of power as zero sum. However, the political rationalities that make these moves "make sense" are less frequently examined, or, are treated as ideology. In this view we see power, in the hands of state and capital, as repressing people's legitimate needs for health. Power therefore functions by obscuring truth. As Walters (2000) explains, these structuralist approaches tend to treat social welfare:

> as a sort of subsystem, as one sector within a larger political, social, and economic totality. Within these structuralist approaches the task of the theorist is to draw out the linkages, homologies, supports, but also contradictions, between the welfare system and other regions of the totality…. Changes in the welfare system are then made intelligible in terms of changes in other regions of the totality – the globalization of the economy, the rise of post-Fordism, or even postmodernity." (p. 10)

Consequently, a very systematized and rational view of society and history is produced, wherein transhistorical entities and essential structures have ultimate causal or explanatory force (p. 10).

Second, the literature tends to treat health as a transhistorical condition. Within this framing there is little space for the consideration of forms of expert knowledge and

governing practices as constitutive of social truths and social realities. Instead, knowledge is treated as ideology, a mask that hides the truth of the social from view. Thus, in the case of the political economy approach to the social determinants of health, we see the concept of socio-economic status as an ideological concept that hides the real and true source of people's disenfranchisement from health. In this view there is less room to see how the production of new truths about the social and spatial determinants of health engender new practices and subjectivities vis-à-vis health. How does the scientific linking of "disorder and deterioration" (Walters, 2000, p. 16) to "unhealth" inform the ways people and communities govern the self and others?

This leads to a third and final blind spot, which is the question of political subjectivity. The literature which deals with the impact of neoliberalism on the social determinants of health tends to function at a high level of abstraction, tracing broad shifts in the global political economy and bringing this to bear on questions of heath inequity. But what kinds of political subjects and modes of citizenship are being produced in and through these shifts? And how are new forms of class and citizenship produced through the knowledge and practice of health in public policy and expert discourses? These questions are not easily answered by looking at them through this lens.

2.2 Critical Political Economy: Gentrification

The critical political economy approach to gentrification understands the historical trajectory from welfare to neoliberal forms of liberalism in terms similar to those of the health literature, and shares with it a conception of power as zero sum. Within the literature on gentrification it is therefore possible to identify a similar pattern of problematization: the crisis in the Fordist regime of accumulation shows up also in land and property markets, leading to a distinctive post-War phenomenon called "gentrification" (Smith, 1979). As

Smith explains, gentrification is inexorably bound up with broader shifts in the global political economy:

> Systematic gentrification since the 1960s and 1970s is simultaneously a response and contributor to a series of wider global transformations: global economic expansion in the 1980s; the restructuring of national and urban economies in advanced capitalist countries towards services, recreation and consumption; and the emergence of a global hierarchy of world, national, and regional cities. (1996, p. 38)

Furthermore, due to its origins in Marxian urban sociology, critical gentrification scholarship has tended to emphasize the phenomenon of displacement of working-class people and lifestyles by the middle class as *the* crucial question to be addressed by gentrification research (Marcuse, 1985; Slater, 2010; Smith, 1979, 1996). Indeed, the term itself was coined by Marxist urban sociologist Ruth Glass in an effort to capture the specificity of this class dynamic, as she observed it in 1960s London.

However, this focus on displacement has been both nuanced (Kern, 2015a, 2015b; Masuda, et al., 2012; Mazer & Rankin, 2011; Teelucksingh, 2002) and directly challenged (Murray, 2015) by scholars recently. Accordingly, this section unfolds in two parts. First, I outline Neil Smith's influential theory of the rent gap, and its articulation of a theory of gentrification as the spatial manifestation of class struggle, understood in binary and zero sum terms (Smith, 1979, 1996). Second, I look at some of the ways that the study of displacement has been extended and problematized, in particular by those looking at the phenomenon of environmental gentrification. I argue that it is the latter group that offers the most productive point of engagement for an analysis of the vital politics of gentrification.

2.2.1 The Rent Gap

Smith's definitive contribution was to articulate a theory of "gentrification" as both a global and local phenomenon (2002), and an historically specific spatial process emerging from the dynamics of post-War capitalism and urban land and property markets (1979, 1996). He

argued that whereas once it may have been possible to see gentrification as "quixotic oddity" of particular localized space, by the 1990s gentrification was "global" in three senses of the word (2002): first, it was happening on several continents; second, gentrification was tied to broader shifts in the global political economy; and third, it was the product of citywide property markets (i.e. relative land values).

The term "rent gap" refers in a dual sense to the difference in property values between disinvested portions of American central cities such as Chicago and Philadelphia and the higher land values of more recently invested middle-class suburbs, and to the "gap" which subsequently emerges between actual and potential ground rent in the disinvested inner city (Smith, 1979, 1996). Of particular importance were the post-WWII years that saw large manufacturing employers relocate from the central city to the suburban periphery in response to the "availability" of more abundant, less expensive land. As employment left the city for the suburbs, so too did public money, which was redirected towards the development of infrastructure to support the emergent phenomenon of suburbia. Disinvestment in the inner city ensued. However, in the post-1970s era, structural changes in the economy and nature of employment brought their own urban spatial manifestation. With the decline of manufacturing and the decline of Fordism, the urban political economy was reoriented towards the provision of services, with the so-called FIRE professions (Finance, Insurance, and Real Estate) growing in importance in the post-1970s urban economy. This in turn brought an attendant spatial logic of concentration and centralization.[4]

[4] The literature on gentrification in specifically Canadian contexts has added a few crucial agents to this list. Slater (2004) has emphasized the role of municipal government in the City of Toronto in promoting "family friendly neighbourhoods" (see also Keatinge & Martin, 2015). Ley (1996) has called attention to the role of the "quaternary professions"—civil servants, government bureaucrats, university professors and so forth—as important players in the overall gentrification puzzle.

As inner city land is re-valued under this logic of centralization and concentration, a ground rent discrepancy emerges: a gap between actual and potential ground rent procured from a given piece of land. Property developers and other gentrifiers capitalize on this gap by purchasing land cheaply, developing it, and re-selling at a handsome profit. The losers in this process are the working-class people who see their neighbourhoods fall into disrepair as a consequence of disinvestment, and who are ultimately displaced in the wake of profitable reinvestments, which bring higher rents, more expensive goods and services, and more affluent residents along with them.

Importantly, Smith (1996) emphasized that the rent gap is not a natural or inevitable occurrence. Rather, it is the outcome of systematic disinvestment in inner cities in the US and other advanced industrial nations. Gentrification is therefore not the consequence of actions taken by a singular group of people, such as middle class homebuyers. On the contrary, it is the urban spatial manifestation of broader macroeconomic processes, and the figure of the middle-class homebuyer "recolonizing" the inner city is but one symptom of this larger process which tends, as capitalist markets are wont to do, to privilege exchange value over use value. The possibility of making a "good investment" in an inner city home is created by the historical trajectory of the movements of capital.

While Smith (1996) does trace land-value-based logics of "disinvestment," this tends to treat the reasoning for post-War disinvestment as a self-evident fact emerging from the very property markets he seeks to critique. Crisis appears as self-explanatory and emerges from the inner workings of capital; similarly, the "availability" of land is a taken-for-granted fact echoing the terra nullius logic of colonialism (Blomley, 2004; Jackson, 2016). Disinvestment follows the land-based needs of capital: as land in the urban centre becomes

more expensive employers move out of the city centre to the periphery, precipitating a broader out-migration.

In Smith's narrative, the details of the spaces and histories of disinvested communities (as well as those newly founded in the suburbs) are treated as secondary to the global history of capital. In this way, the environmental histories of people and communities and the specificities of particular struggles over the use and definition of land and property are written out of the picture. So too, the theory of the rent gap implicitly treats capitalist land markets as *the* significant sites for the production of value (Murray, 2015). Accordingly, all spatial difference is treated as reducible to differences between the value of land as it is understood by, and circulated within, capitalist land markets. Other features of space and spatial production, including, somewhat ironically, its use value by different urban residents, is given much less consideration. Accordingly, power, as wielded by capital with the support of the state, works to repress and displace. Within this view there is less room to examine how space and subjectivity are materialized through forms of governance and the production of new truths about life, health, and populations.

2.2.2 Nuancing Displacement: Health and Environmental Injustice

Displacement has been deepened and extended from its original emphasis on the physical displacement of working-class bodies and replacement by middle-class ones. Importantly, while Glass is often remembered for a focus on the specific problematic of housing, she was also attentive to the broader changes to the urban landscape which are constitutive of the process, associated with the greater affluence of its new residents. This affluence, she writes,

> shows itself in an abundance of goods and gadgets, of cars and new buildings–in an apparently mounting flow of consumption. There are far more soft and hard eating and drinking places than there used to be (and they are open for longer hours). The shops are crammed with personal and household paraphernalia which had previously never been mass-produced nor for mass use. The wrapping and the labeling of commodities–small or large, practical or ornamental, frozen or fresh, dehydrated or

> puffed up-have a new gloss. The luxuries of yesterday, or the imitations of yesterdays luxuries have become the necessities of today for large sections of the population. (1964, p. xiv)

In a similar fashion, recent research has broadened the discussion around what constitutes displacement to show how the exclusions produced by rising rents and the changing nature, cost, and availability of essential goods and amenities, such as food and public space, translate into different forms of material and symbolic exclusion from urban space and public life more generally (Keatinge & Martin, 2015; Kern, 2015a, 2015b; Kohn, 2013; Masuda et al., 2012; Mazer & Rankin, 2011; Wolch, Byrne, & Newell, 2014; Zukin, 2009).

Environmental gentrification has been an especially poignant area of scholarship, as it addresses the complexities surrounding processes of urban neighbourhood change that take place in the name of "sustainability," "health," and/or the redress of environmental injustice (Checker; 2011; Cidell, 2009; Curran & Hamilton, 2012; Kern, 2015a; Wolch, Byrne & Newell, 2014; Teelucksingh, 2002). For example, studies have shown that predominantly white neighbourhoods tend to have more green space and higher "walkability" scores, and, presumably, more opportunities for "health" (Wolch, 2014). At the same time, poor and racialized communities are more likely to be living near locally undesirable land uses (LULUs) such as previously contaminated land and water or presently active polluters (Teelucksingh, 2009). Environmental gentrification may take place either when a formerly industrial site is redeveloped for residential or mixed-use purposes (Bruce, 2009), or, when there are efforts to remove pollutants in or near existing residential neighbourhoods (Checker, 2011; Curran & Hamilton, 2012). In the former case the "instant" gentrification (Teelucksingh, 2009) of brownfields redevelopment is seen as part of a broader trend in which the city is remade as a post-industrial space of leisure and consumption (Zukin, 1987),

privileging the lives and bodies of a "new middle class" (Ley, 1996) over the housing needs of lower income people.

In the latter instance, environmental gentrification may arise from the efforts of local residents and activists to address forms of environmental racism and racialization (Curran & Hamilton, 2012); or, it may represent efforts to build on "the material and discursive successes of the environmental justice movement" and appropriate them "to serve high-end development" (Checker, 2011). In either case, this literature illuminates how the process of "cleaning up" formerly industrial areas of the city in the name of health and environmental justice may also have negative effects including reduced affordability of housing (Teelucksingh, 2009); diminished access to services (Kern, 2015a, 2015b); increased surveillance and policing (Braverman, 2008); and reduced access to the public sphere and to forums through which governmental problems are formulated and definitions of what exactly constitutes "good," "green," or "healthy" uses of space are decided (Checker, 2011).

The problem is a complex one, since efforts to clean up industrial contamination or to address other kinds of environmental health risks may originate from residents themselves, including long-standing residents. Yet forms of "environmental cleanup may allow for the realization of the rent gap" (Curran & Hamilton, 2012) and, therefore, open the door to associated displacement effects. As Checker (2011) and Wolch, Bynre, & Newell (2014) have separately argued, in practice the language of "sustainability" that informs these types of efforts tends to privilege ecological sustainability at the expense of social sustainability (see also, Bruce, 2009). These scholars therefore argue that policy solutions should be "just green enough" (Curran & Hamilton, 2012), meaning that communities and policy makers should strive for solutions which are able to bring environmental benefits without generating displacement pressures.

This suggests, of course, that key categories such as sustainability, and also "health," "cleanup," and "greening" are not strictly objective categories. Instead, they are given meaning and content in the discourses and struggles through which they are enacted. Whereas some efforts to rehabilitate industrially contaminated urban space for re-use and rezoning as residential and mixed-use development might focus on specific environmental pollutants and toxins to be removed, in other instances the concept of "cleanup" might be deployed more liberally, to include removal or marginalization of things as well as people deemed "out of place" or undesirable by agents of gentrification (Kern, 2015a). The way in which these terms are deployed may also depend on who is using them, whether business and residents associations, municipal authorities or individual property owners. In highlighting these dynamics scholars have called attention to the ways in which bodies and spaces are produced relationally through discourses, rationalities, and forms of common sense about who belongs where and what constitutes a "good" or "healthy" use of space (Kern, 2015a; Masuda et al., 2012; Teelucksingh, 2002). Here, land and space are treated as dynamic categories that are made and remade, not simply inhabited or used, by myriad different actors and as a result of contestations around forms and modes of valuation. To this end, Teelucksingh (2002) developed the notion of environmental racialization, which is distinct from that of environmental racism. For Teelucksingh, the latter concept treats space as a static entity. Racialization, by contrast, calls attention to the fact that "space" does not exist independently from the bodies that inhabit it and the ideas and the practices through which it is continually made and remade.

Feminist geographer Leslie Kern (2010) argues, "spaces of crime and decay" are sometimes mapped onto particular bodies in governmental and everyday discourses about space. Consequently, "the homeless, the poor, racialized minorities, those with disabilities or

mental illnesses, sexual minorities and sex workers have all been targeted for removal by revitalization campaigns" (p. 29). These bodies in turn are made, by symbolic agents of gentrification, to "mark spaces as diseased and 'other'" (2010, p. 29). The language of gentrification, by contrast, "implies an infusion of health to this diseased body/space: revitalization, renewal, replenishment, new 'lifeblood'" (p. 29). Other bodies are symbolically marked as "good" and "healthy" through diverse practices, including forms of consumption (Kern 2015a, 2015b), and municipal policies that privilege familialism, for example.

Political scientist Karen Murray has extended these debates by showing the limits of an emphasis on displacement in studies of the "gentrification-social mixing nexus" (2015, p. 278). For Murray, "the almost singular focus on land use and property defines low-income and disadvantaged people as self-evident hindrances to profitability" (p. 278). This prevents political economy analyses of the gentrification-social mixing dynamic from sufficiently analyzing the extent to which governmental practices may work to naturalize poverty in situ, in ways that create material benefits—including financial benefits, research grants, and individual and institutional influence and prestige—for researchers and policy makers studying the problem of poverty and its impacts on the new imperative of human development. Taking the East Side of Vancouver as her empirical case, Murray shows how consensus around social mixing policies was produced through its association with neuroscience and an emergent regime of truth that associates early childhood brain development with the neighbourhood scale, and the character of its social and physical environments. In this way, Murray argues that in the "gentrification intensive" area of East Vancouver "social mixing interventions are connected to processes that turn the biological existence of disadvantaged people into raw material for profit" (p. 278).

This latter body of research challenges gentrification studies to delve further into the question of how truths about which kinds of places and bodies come to be understood as "good," "healthy," "vital" and, ultimately, *habitable*, are produced, and with what kinds of consequences, and for whom. As Murray writes: "the biopower lens does not assume that displacement is the only or dominant spatial tactic. And whereas gentrification trains attention on land and property values, biopower allows an entry point to assess value-generating dynamics at the level of biological existence" (p. 279). More broadly, a singular emphasis on displacement obfuscates the extent to which strategies of allocating and governing bodies in space is central to the operation of modern forms of knowledge-power (Foucault, 1997, 2000a, 2000b). Thus, studies of gentrification can be enhanced by paying attention to the political logics pertaining to how bodies and spaces are problematized in relation to one another.

2.3 Neo-Foucaultian Perspectives: Biopolitics, Space, and Health

A key difference between political economy and neo-Foucaultian perspectives is the conceptualization of power. In the political economy literature we see state and capital collude to take health and life-giving resources away from particular segments of the population, such that more of these finite resources can be made available for others, in the "ruling class." Foucault called this form of power sovereign or deductive: the power to take life, money, and things. However, Foucault diagnosed another form of power, which he called biopower, and which he argued emerged and grew in importance in Europe between the late 17th and early 19th centuries. Biopower is a productive and productivist form of power. It operates in large measure through the formal freedom of subjects and seeks to cultivate their life, vital capacities, and productive energies by drawing them together, making

them grow, and organizing them for controlled insertion into the productive apparatus (Foucault, 1977, 1998; Lemke, 2011).

Biopower is intricately bound up with the 18th century discovery of the phenomenon of population (Foucault, 2007). This was the discovery that population has its own proper characteristics, trends, and patterns. For example, birth rates, death rates and the like, display a kind of regularity which, once observed can become an object to be governed in ways that augment the wealth and power of territorial authorities. Here, medicine and sexuality occupy crucial sites of knowledge production, since it is through these arenas that the health, longevity, and productivity of the individual can be linked to that of the collective or the population (Foucault, 2007). It is the linkage of these poles—the biological life of the individual and that of the species—to which the term *biopolitics* specifically refers (Lemke, 2011).

Biopower does not replace sovereign power, and neither does it deny its existence (Lemke, 2011; Taylor, 2011). Rather, an analytic of biopower highlights the ways in which it comes to exist with it in different forms and constellations at different times. And, accordingly, while it is possible and necessary to identify specific instantiations of biopower, it not something over which "state" or "capital" have a monopoly. Rather, we may see other kinds of institutions, such as the church, organized medicine, or academic disciplines as key agents of biopower. As Foucault explains:

> In the eighteenth century we find a further function emerging, that of the disposition of society as a milieu of physical well being, health, and optimal longevity. The exercise of these three latter functions – order, enrichment and health – is assured less through a single apparatus than by an ensemble of multiple regulations and institutions which in the eighteenth century take the name of 'police'. Down to the end of the ancient regime, the term 'police' does not signify (at least not exclusively) the institution of police in the modern sense; 'police' is the ensemble of mechanisms serving to ensure order, the properly channeled growth of wealth, and the conditions of preservation of health 'in general.'" (2000c, p. 94)

Neo-Foucaultian scholars therefore show us how relations of power unfold through forms of knowledge and truth about health and biological life (Fusco, 2006; Lemke, 2011; Metzl, 2010; Murray, 2015; Rose, 2007) making particular forms of politics and political subjection possible (Crawford, 1980; Metzl, 2010; Lavernce & Lozanski, 2014; LeBesco, 2010; Lupton, 1995; Rose, 2007; Stacey 1994), including through techniques of space and spatialization (Fusco, 2006, 2007; Herrick, 2008; Kern, 2014; Murray, 2015).

2.3.1 Health as Knowledge-Power

Neo-Foucaultian scholarship on the subjects of health and health care emphasize "health" as a form of knowledge-power which enjoins people and collectives to organize knowledge and behavior in ways that strive to protect, and, increasingly, to modify and optimize, human biological existence (Fusco, 2006; Lemke, 2011; Lupton, 1995; Murray, 2015; Polzer & Power, 2016; Rose, 2007). In so doing, they call attention to specific forms of knowledge and expertise and the practices, institutions, and social relations through which forms of knowledge circulate. These include policies around physical activity and recreation for youth, and the governance of spaces of such activity (Fusco, 2006, 2007).

Discourses, including policy discourses about heath, are treated as productive rather than merely reactive or repressive (Fusco, 2006, 2007; Herrick, 2008; Klassen, 2011; Lavernce & Lozanski, 2014; Lupton 1995; Osborne, 1997; Metzl, 2010; Polzer & Power, 2016). Here, forms of liberalism, be they "welfarist," or "neo," or "advanced," are constituted through diverse tactics and strategies that do not necessarily add up to a coherent ideological program. Rather, because government and governance are broadly conceptualized as taking place "at a distance" and across myriad sites not obviously associated with formal politics, these studies highlight the role of "health" as a form of knowledge-power and expertise for shaping conduct and subjectivity in settings such as

locker rooms and playgrounds (Fucso, 2006, 2007), ethopolitical retail chains such as Lululemon (Lavernce & Lozanski, 2014) and Whole Foods (Power, 2016), and privately sponsored charitable fundraising events (Herrick, 2008).

In an era in which the definition of "health" has shifted away from the treatment of disease and restoration to "normal," and towards an emphasis on susceptibility, prevention, and optimization (Morris, 2000; Rose, 2007), childhood and youth take on particularly important significance, since this is where the chances and capacities of the future generation of productive beings lies (Fusco, 2006; White, 2011). Thus we see a proliferation of knowledge and practices aimed at childhood and optimal childhood development, in diverse areas of governance (Chödrön, 2015; Fusco, 2006; Murray, 2015; Power, 2016; White, 2011).

A collection of essays provocatively titled *Against Health* (Kirkland & Metzl, 2010) echoed Foucault's assertion that "it's not that everything is bad, but that everything is dangerous" (cited in Dreyfus and Rabinow, 1983, p. 231). In the introduction to the volume, American medical sociologist Jonathan Metzl outlines the paradox as well as the necessity of treating health discourses as forms of knowledge-power: "How can anyone take a stand against health?" (p. 1) It is precisely because liberal societies govern subjects through their will to health and longevity that a critical stance towards the subject appears somewhat strange: what, after all, "could be wrong with health? Shouldn't we be *for* health? Furthermore, isn't this especially true in contexts where there is so much good evidence of inequality in health status and access to health care?" (Metzl, 2010, p. 1). However, Metzl goes on to state that limiting oneself to arguing for the redistribution of health care or other health-related resources has a crucial blind spot:

> arguments supporting the reallocation of resources understandably assume that health is a fixed entity that can be transported from one setting to another. The rich have health, for instance, and the poor do not. While valid, such claims overlook the ways in which health is part of the problem that we mean to address. (2010, p. 1)

Scholars therefore write of the "imperative of health" (Lupton, 1995), "healthism" (Crawford, 1980; Lavernce & Lozanski, 2010; Metzl, 2010), and "healthification" (Dean, 2016; Fusco, 2006, 2007) to unpack how "health" is central to the ways in which diverse social and political problem spaces, such as crime and urban inequality, as well as their ostensible solutions in street trees, playgrounds, and urban parks (Braverman, 2008; Checker, 2011; Fusco, 2007), are conceptualized.

Originally introduced by American political economist Robert Crawford in 1980, the concept of "healthism" is garnering renewed attention by neo-Foucaultian writers who examine techniques through which individuals are encouraged to govern themselves and others according to new "neoliberal" and "entrepreneurial" modes of citizenship, "which understand health as a personal, moral achievement" (Lavernce & Lozanski, 2014; Power, 2016; see also Kirkland & Metzl, 2010). Crawford saw healthism as emerging out of critiques of medicine associated both with the rise of the New Public Health (Lalonde, 1974) and holistic and self-care health movements in the US in the 1970s. He defined the concept as a particular and depoliticized "way of viewing the health problem" that "is characteristic of the new health consciousness and movements. It can best be understood as a form of medicalization" in that "like medicine, healthism situates the problem of health and disease at the level of the individual. Solutions are formulated at that level as well" (1980, p. 365). As with contemporary writers such as Lavernce and Lozanski (2014), Metzl (2010), and Power (2016), he argued that healthism is moralizing: "by elevating health to a super value, a metaphor for all that is good in life, healthism reinforces the privatization of the struggle for generalized well-being" (Crawford, 1980, p. 365). Crawford argued that the salience of the individualism of the self-care and wellness industries was made possible by the emergence of the new public health and the emergent truth regime on which it was based: the argument

that by and large major improvements in morbidity and mortality rates in the 19th and 20th centuries were not attributable to medicine and formal health care, but to matters beyond formal health care such as improved nutrition and living standards. In the 1970s and 1980s this had the effect of shifting debates in health care away from equal access and towards individual responsibility. The concept of healthism therefore points to a particular historical moment when the truth about what health is, and how and where it is achieved, began to shift. The extension of the analysis of healthism requires contextual analysis that takes into consideration developments since the birth of the new public health, as well as national and local specificities.

In sum, neo-Foucaultian oriented analyses extend political economy analyses which "emphasize the state's role in supporting processes of privatization, deregulation, and cuts to social spending" as the "general tenants of neoliberalism" (Polzer & Power, 2016, p. 12). They do so by shifting focus to the specificity of how different forms of liberal thought are "concretized into specific practices, and in specific contexts, to shape discourses on health as well as opportunities for health" (Polzer & Power, 2016, p. 12).

2.3.2 Space and Populations

Space was a crucial dimension for Foucault in the analysis of biopower (Armstrong, 1997; Foucault, 1977, 2000b, 2000c; Osborne & Rose, 2004). In the classical age, or the 17th century, according to Foucault, the problem of health and illness, in terms of the services provided was one of poverty (2000c). Moreover, unlike the highly differentiated notions of "poverty" in the 19th century (idle, able bodied, deserving, undeserving, etc.), in the 17th century, medicine practiced and understood as a service was synonymous with "assistance" to a largely undifferentiated category of "sick poor" (Foucault, 2000c). However, in the 18th century, under the influence of new forms of expert knowledge and new ways of seeing they

were bound up with, the category of "sick poor" began to be "carved up" in new ways. The new type of analysis sought to make poverty "useful" either by connecting it to a productive apparatus in new ways, and/or by making poverty effectively "bear its own cost" in terms of food, shelter, education, or care of abandoned children that had formerly been provided by charitable foundations: "This dismantling is carried out or, rather, is called for (since it only begins to become effective late in the century) as the upshot of a general reexamination of modes of investment and capitalization" (2000c, p. 93).

Furthermore, these new categories of people and forms of poverty and ill health would not have been possible without the new forms of observation that the new disciplines made both possible and necessary: "The process of dismemberment is also carried out as a result of a finer grid of observation of the population and the distinctions this aims to draw between the different categories of unfortunates to which charity confusedly addresses itself" (2000c, p. 93). Foucault argued that spatial dynamics were integral to these shifts. New problematizations of bodies and their relation to the production of wealth were bound up with specific ideas about the appropriate distribution of bodies in space, and according to identifiable logics of dispersion, concentration, isolation, and so forth. In short, in the political problematization of the health, vitality, and productive forces of bodies we also find specific *problematizations* of space, as well as *uses* of space as a technique for the management of bodies and their productive energies. Thus, attention to the ways in which space is both problematized and operationalized in political discourse can produce unique insights into the workings of biopolitical governance.

Many writers in both political economy and neo-Foucaultian traditions emphasize the individualizing dimensions of transformations in health provisioning and epistemologies of "neoliberal" or "advanced liberal" modes of governing. This individualizing dynamic is

important, since the normalization of the assumption that health "is a personal moral achievement" (Lavernce & Lozanski, 2014) obscures the fact—so effectively pointed out in the critical political economy literature—that health is a social phenomenon, the product of class, gender, and race. However, the focus on the individualizing tendencies obscures the equally important dynamic of what Foucault referred to as the massifying tendencies of biopolitics. Yoga, for example, may be individualizing, but it is also clearly a mass—if not exactly a collective—phenomenon. How else to explain the fact that so many young, white, female urbanites are doing it? Whereas the retreat from collective provisioning associated with the welfare state has surely been bound up with individualizing tendencies, there is more to be said about the "massifying" dimensions of contemporary biopower. In particular, these massifying tendencies can be seen and analyzed through an attention to the spatial dynamics of these transformations.

To this end, and building on the concept of healthism, some scholars have highlighted the techniques of governing space as massifying strategies that produce particular kinds of populations. Addressing contemporary politics of liberal subject formation, sociologist Caroline Fusco developed the notion of the "healthification of space" (Fusco, 2006, 2007). Fusco's analysis shows how particular kinds of relations to self and others are brought into being through the management of space in the name of promoting health. Here, "health" functions as a technique through which dominant social relations are spatially reproduced through the individualizing and massifying tendencies that converge in the techniques of space. Likewise, in her research on obesity and "philanthropic entrepreneurialism" as a form of governance and subjectification, geographer Claire Herrick (2008) shows how spaces of "health" and "obesity" are produced as relational and racialized spaces through a complex set of practices involving businesses, philanthropists, and state

bureaucrats in Austin, Texas. East Austin, she argues, has become marked out for obesity prevention programs based on "the misleading conflation of state-scale health data demonstrating higher obesity prevalence among Hispanic children with an identifiable and named space… that has, historically, been poorer than the rest of the city and minority dominated" (p. 2731). These group- or population-level identities—white "normal" bodies and Hispanic "excessive" bodies—are produced relationally through spatialized knowledge that is concretized in the practices of state bureaucrats and public health officials, the activities of "philanthropic entrepreneurs," and the actions of ordinary citizens. Herrick's analysis therefore raises a key question for studies of health, governance, and subjectivity. In the context of the new public health "as a form of medicine, social medicine, which directs its professional attention towards the health of populations, aggregated bodies, instead of individual bodies" (Lupton, 1995, p. 2), it is necessary to ask just how the relation between "individual" and "mass" is practiced in or own era of biopolitics.

2.3.3 A Vital Politics of Space?

The foregoing discussion points to the need for an assessment of the shifting terrain of governance through which health as a form of knowledge and an embodied corporeality is produced. In particular, the question of *vital politics* asks us to consider experts and forms of expert knowledge-power as relational and historical. In addition, it asks us to consider that power in general and relationships for governing the conduct of self and others in particular are not confined to "states" or "markets," but rather take place through myriad actors at different scales with effects that may or may not produce coherent programs and diagrams of power. As more familiar governmental actors and activities recede or are de-emphasized what new agents and practices come to the fore? And, What are their spatial assumptions and effects?

As this dissertation shows, the emphasis on neighbourhoods in contemporary forms of knowledge-power pertaining to health can be understood as a new way of bringing the longer-standing concern with urban space and urbanization into visibility relative to biopolitical concerns with national health and welfare. Indeed, the "urban" appears frequently in the Canadian biopolitical and governmental problematizations of health. Viewed from the vantage of "health," urban space and the process of urbanization have appeared both as necessary and problematic in the Canadian political imaginary of the past 75 years. They are necessary in the sense that the urban is the spatial form of capitalist development, and the process of urbanization is therefore bound up with notions of capitalist "progress." However, the urban is also deeply problematic, since it is the place where the "dark side of progress," as former health minister Marc Lalonde once put it, is most visible and concentrated.

3. Methodology: Discourse, Genealogy and the Study of Practices of Governing

3.1 Archeology and the Politics of Discourse

Foucault used the term "archeology" to suggest the description of an archive, which he explained, does not mean "the mass of texts gathered together at a given period, those from some past epoch which have survived erasure." Rather, the archeological method sets out to describe rules which "at a given period and for a given society" define "the limits and forms" of what is sayable, what it is possible to remember, and, therefore, what can be reactivated in the fields of human knowledge and practice (Foucault, 1991, pp. 59-60).

Foucault sought to show how discursive formations are governed by rules that are not causal or rules which speakers consciously understand themselves to be following.

Rather, they are rules that govern the "regularity and rarity of statements" (Dreyfus & Rabinow, 1983). In the archeological method, an important part of what Foucault did was to "bracket" truth and meaning. Unlike hermeneutics, which seeks to find the deep meaning of statements, Foucault argued that there was no pre-discursive truth to be sought and uncovered. Discourse itself is productive of truths. This did not mean that discourse merely "invented" truth and reality. Rather, it meant that the specific mode of formulating a problem, an answer, or a question, needed to be understood in relation to the fact that there *might have been* other formulations or other conceptualizations. Thus, the critical question becomes: how does *this* specific problem, rather than some other problem, take shape? What kinds of events can be identified that allow new discourses or modes of problematization to take shape, or for older ones to be remembered and reactivated?

> I do not question discourses about their silently intended meanings, but about the fact and the conditions of their manifest appearance; not about the contents which they may conceal, but about the transformations they have effected; not about the sense preserved within them like a perpetual origin, but about the field where they co-exist, reside and disappear. It is a question of an analysis of the discourses in the dimension of their exteriority." (Foucault, 1991, p. 60)

The archeological method suffers from some key tensions and failings. Chief among them is the relationship to power, truth, and meaning: can the archeologist truly stand outside of the formation she or he analyzes? And if bracketing truth and meaning are fundamental prerequisites of such an analysis then what meaning can the analyses and pronouncements of the archeologist have (Dreyfus & Rabinow, 1983)? Pushing against these tensions, in the 1970s Foucault began to develop the genealogical method used in what are perhaps his best known works: *Discipline and Punish* and *La Volonte du Savoir* (Dreyfus & Rabinow, 1982). As philosopher Richard Dreyfus and anthropologist Paul Rabinow argue: "without getting into a futile game of classification–early, middle, late… we can see that from his earliest days Foucault used variants of an analysis of discourse (archeology) and

paid a more general attention to that which limits, conditions, and institutionalizes discursive formations (genealogy)" (p. 104). Thus, they argue, "*There is no pre- and post-archeology and genealogy in Foucault"*. Rather, it is the "weighting and conception of these approaches has changed during the development of his work" (1983, p. 104). Thus, while discourse remains a key component of genealogical analysis, it is no longer treated as an autonomous and self-generative system (p. 104). And, in the move towards genealogy the emphasis on the body as subject and object of knowledge-power comes to take centre stage (Dreyfus & Rabinow, 1983).

3.2 Genealogy: Mapping "Descent" and "Emergence"

Genealogy differs from both mainstream and Hegelian-Marxist approaches to history in a number of ways. First, genealogy does not seek to find the singular origin of concepts, processes, or events. Second, its objective is not to reconstruct an historical episode or period in its purity or authenticity. And, third, it does not look to the past with a view to discovering what is the same, or what has always been there waiting to develop, like the acorn which harbours within in it the fully grown oak tree. Genealogy, by contrast, "maintains events in their proper dispersion" (Foucault, 1998a, p. 374). It identifies accidents, errors of judgment, "faulty calculations," and "complete reversals" that "gave birth to those things which continue to exist and to have value for us" (p. 374). And accordingly, genealogy is a method which, rather than "erecting foundations," "disturbs what was previously considered immobile" (p. 374). Fourth and finally, genealogy directs itself towards the articulation of the body and history (p. 374), instead of either treating the body and the subject as transhistorical or taking some other entity, such as "society" as the subject of history (Foucault, 1997).

Genealogy displaces the search for "origins" in favour of an analysis of emergence and descent. The search for origins is, for Foucault, associated with the discovery of historical sameness, universal truths, and the unfolding of "destiny." The genealogist, by contrast, studies "numberless beginnings, whose faint traces and hints of colour are readily seen by an historical eye." In the analysis of descent the genealogist is therefore attentive to the "myriad events through which – thanks to which, against which" concepts are formed (Foucault, 1998a, p. 374).

> Genealogy does not pretend to go back in time to restore an unbroken continuity that operates beyond the dispersion of oblivion; its task is not to demonstrate that the past actively exists in the present, that it continues secretly to animate the present, having imposed a predetermined form on all of its vicissitudes. (p. 374)

Thus, the task of the genealogist is to "follow the complex course of descent… [and] maintain passing events in their proper dispersion" (p. 374).

Emergence is another concept on which Foucault elaborates as important to the genealogical method. He writes: "As it is wrong to search for descent in an uninterrupted continuity, we should avoid accounting for emergence by appeal to its final term" (1997, p. 376). When looking for the emergence of a practice or a discipline, whether in the field of punishment or public health, we should not assume that the rationalities which inform a current instantiation have been there all along. On the contrary, the task is to map the shifts and differences that lie behind superficial similarities. In this way we can avoid the hubris of assuming our current moment as a culmination, a high point, or a result of "progress." Instead, we can see our current predicaments as "merely the current episodes in a series of subjugations," and therefore as part of, and not totally or partially exempt from, knowledge-power and "the hazardous play of dominations" (p. 374).

According to Walters (2000), genealogy provides an alternative to the "highly systematized and rational image of the world" offered in structuralist approaches in two

ways. First, genealogy is "unapologetically superficial in its outlook." This means that we can gain important insights into the past and present without looking for deep, repressed, or ideologically mystified eternal truths. Instead, genealogy focuses on "surfaces," and takes discourses at their word in order to "trace out the imagined spaces and territories of government" (p. 10). Genealogy treats presumed categories such as "society," "economy," and "state" as constituting historically and geographically specific divisions and demarcations which themselves require analysis and critique. Second, whereas structuralist-type analyses tend to proceed from general to particular (i.e. changes in the economy writ large precipitate changes in particular realms of governance), genealogical approaches pay more attention to the multiplicity of particulars, holding, by contrast, that broad changes "are the culmination of a multitude of smaller changes, of distinct lines of development which do not evolve simultaneously" and which "combine in unpredictable ways" (p. 10).

In the development and emphasis of genealogy, Foucault abandoned an earlier stance on the possibility of the archeologist as a disinterested and neutral observer who can only ever comment on ruptures and transformations in discursive formations in the past, in an era which is not one's own (Dreyfus and Rabinow, 1983). Genealogy is expressly normative in its use of history. It revisits episodes and events from the past with an eye for detail and trains attention on those that help us to see the specificity of contemporary articulations of politics.

In the course of developing the genealogical method Foucault focused increasingly on the nexus of the body and knowledge/power. Foucault (1997) held that the body and subjectivity were *historical*. He sought to disrupt what he saw as modes of treating bodies and subjects as either trans-historical universals, or not really "treating" them at all, preferring instead to take entities such as society or social forces as the subject of history.

> I have tried to get out from the philosophy of the subject through a genealogy of this subject, by studying the constitution of the subject across history which has led us to the modern concept of the self. This has not always been an easy task, since most historians prefer a history of social processes [where society plays the role of the subject] and most philosophers prefer a subject without history. (1997, p. 150)

Thus, Foucault strove to bring differences and changes in the constitution of corporeal and embodied experience into visibility.

In postulating that knowledge and power are inextricably linked, Foucault rejects the possibility that knowledge can ever stand outside of power and produce a more pure knowledge that stands in opposition to it. This is not to say, however, that critique of knowledge-power is not possible, or, indeed, absolutely crucial. On the contrary, Foucault asserts that critique is precisely the discursive and non-discursive practices that enable an articulation of "how not to be governed," or, at least how not to be governed in the name of this or that interest or technique of power (1997, p. 44). The project of critique is not about pointing to what is wrong, but what kinds of assumptions, rationalities, and forms of self-evidence underwrite predominant forms of knowledge-power. Thus, even though we do critique and must critique knowledge-power, this critique does not free us from it, though it may affect a shift within it. Here, power is not an object, a finite entity, or a thing to be possessed or not. It is a relational entity which inheres in the will to knowledge. The task of the genealogist operating under this understanding of knowledge-power is thus not to lead us to the end of history and the end of power relations. It is the rather more modest goal of making the workings of knowledge-power *visible* and thus available to critique and transformation.

In his work on the biotechnology industry and its shaping of a "politics of life itself" Nikolas Rose (2007) has argued that Foucault's commitment to shaking up such "immobile" and taken-for-granted truths is less relevant in our own era of rapid technological change

where new groundbreaking discoveries and hence new truths about human life and biology happen with dizzying speed. In such a context, Rose argues, the task of the genealogist is to keep up and to document the work that this politics of life is made to do in the world. While this argument makes sense in the context of biotech and other spheres dominated by corporate for-profit research interests, this is less true of the relatively slow worlds of bureaucracy, public policy, and urban governance. Moreover, even though public health, as a discipline, makes use of new research and knowledge in fields such as neuroscience, epigenetics, and epidemiology, it is also very much a discipline for which notions of its historical origins and authenticity play an important role in its self-constitution. For these reasons, genealogy, as a method of "disturbing the immobile" and of highlighting the multiplicity and contingency of trajectories, remains an important tactic.

3.3 Practices of Governing

Socio-legal studies scholar Marianna Valverde (2007) argues that, taken as a whole, the analytic focus of Foucault's corpus, which his lecture courses in the 1970s bring into sharper view, was on practices of governance and the power struggles through which these practices are constituted. Importantly, Foucault was able to demonstrate that practices of governance were not always historically tied to states or governments, but that the problem of "government," to which the phenomenon of population gave rise and with which it was bound up, was much broader:

> Government was a term discussed not only in political tracts, but also in philosophical, religious, medical and pedagogic texts. In addition to control/management by the state or the administration, "government" also signified problems of self-control, guidance for the family and for children, management of the household, directing the soul, etc. (Lemke, 2001, p. 2)

In short, the problem of government was rearticulated by Foucault through his historical studies to be one of the government of self and others, or in Foucault's formulation, the "conduct of conduct" (Lemke, 2001).

The focus on government and power is significant in that it allowed Foucault a means of speaking about power that did not entail the generation of a "general theory": "the analysis of the mechanisms of power… is not in any way a general theory of what power is. It is not a part or even the start of such a theory" (Foucault, 2007, p. 1). However, such protestations notwithstanding, as Valverde argues, in his published works Foucault sometimes gave "the impression that he was putting forward an alternative theory of modernity." This tended to lead to "epochalist" readings of his work (Valverde, 2007, p. 160), whereby one form of power was seen as replacing another, such that, for example, biopower replaced sovereign power at some point in the 18th century. In Valverde's reading Foucault was interested in showing the materiality and multiplicity of different forms of power "regarded as pragmatically put together collections of governing techniques whose success or failure depends on their usefulness not to 'society' but rather to contenders in particular battles or struggles" (p. 161).

An analytic of biopolitics is as much a methodological commitment as it is a theoretical or conceptual one. As Valverde writes: "What emerges from Foucault's substantive work is that the scholar's task is not to philosophize about power but rather to map the historical fortunes and misfortunes of different forms of power" (2007, p. 161). Further, that the "methodological revolution" inaugurated by Foucault in his 1976 and 1978 lecture courses in particular was brought about through "a focus on practices… rather than either epochs or generalized modes of power-knowledge" (Valverde, 2007, p. 160). The focus on practices similarly means that the analytics of power is "site specific" (p. 160).

Thus, the analytical and methodological inheritance of biopolitics suggests a trio of interlocking sites: knowledge-power, governmental practices, and subjectification.

A Foucaultian-inspired genealogical approach has particular implications for the study of public policy. First, since knowledge and power are constitutive, not oppositional, entities, policy is treated as a positive domain (Osborne, 1997). This is in contrast to conventional approaches which understand the role of policy as identifying a gap in or lack of governmental activity. As Murray explains (2007), standard textbook definitions "define power and politics in relation to what the state does or does not do" (p. 161). In this sense, the "public" in public policy functions as "a synonym for programs and activities funded by government tax revenues and undertaken by official institutions of power such as legislatures, courts, and bureaucracies generally referred to as 'the state'" (p. 161). However, as Murray argues, in the "latter years of the twentieth century this focus was called into question as states began to more actively promote extra-state domains in areas once thought to the appropriate purview of public action" (p. 161). Murray argues that one "manifestation of this shift was the growing emphasis placed on voluntary, non-profit, and philanthropic entities – 'communities' as central domains in the design and delivery of services and resources to address issues of social and economic disadvantage" (p. 161).

For Foucaultian scholars, policy constitutes its domains of action through specific types of governing rationalities and problematizations. But this does not mean that "reality" is invented or constructed by policy or any other type of discourse: "Problematizations are not modes of constructing problems but active ways of positing and experiencing them. It is not that there is nothing 'out there' but constructions, but that policy can not get to work without first problematizing its territory" (Osborne, 1997, p. 174). What this means is that policy is not fundamentally reactive. It does not begin by positing a lack or identifying

"certain agreed upon intolerabilities" which must be addressed either thought progressivist knowledge or more holistic or critical interventions. Instead, from the perspective of problematizations, policy is "fundamentally a creative rather than a reactive endeavor" which in turn means that "policy can never just be about anything…. On the contrary the function of problematizations is to reduce complexity, to provide a field of delimitation regulating what can and can not be said" (pp. 174-175). In this way, governing is broadly understood as being about how certain ways of thinking and acting are normalized across different sites, and consequently, what kinds of subjectively relating to self and others are sought or encouraged by specific techniques of governing.

4. Organization of the Dissertation and Research Steps

4.1 Organization of the Dissertation

The dissertation consists of two main parts. The first (Chapters 2-4) seeks to understand contemporary spatial problematizations of health in light of those that came before. To this end it pursues a genealogy of the relationship between space and how health is conceptualized and problematized in the expert discourses of key public policy events over the course of the period between the expansion of public health in the early 20th century to the late 1990s, when a novel understanding of health as locally determined began to take shape as a truth regime from which we have yet to emerge.

In the 1970s, in Canada and elsewhere, health began to be problematized in a new way that brought the urban spatial imagination into the foreground. In the 1990s the (re)discovery of health as socially and environmentally determined was made possible by new research techniques and findings in the fields of history, epidemiology, sociology, and neuroscience. But the very presentation of this new knowledge and research paradigm *as*

discovery presumes a universal and transhistorical truth lying in wait, to be discovered once the knowing intellect has finally peeled the layers of mystification back far enough. At the same time, the act of rediscovery transforms the "old" public health into a monument to be worshiped and revered. This obscures that fact that even while public health has made important accomplishments, it has also been bound up with more problematic aspects of colonial and class history (Valverde, 1991). Similarly, the contemporary idea that health is socially and environmentally determined carries with it an always implicit and sometimes also explicit spatial imagination, which is in large measure trained on the real and imagined spaces of the urban milieu, and may have vastly different implications for different subjects of governance.

In the second part of the dissertation (Chapters 5 and 6), I present an analysis of how contemporary modes of governing through the vitality of urban populations has unfolded in Parkdale, and the ways in which "health" and "vitality" have become constitutive aspects of material struggles to define, enact, and inhabit space. Parkdale is characterized by an uneven process of gentrification. For example, the formerly working-class and mixed light-industrial character of the area has all but disappeared from the landscape of the northern part of the neighbourhood since the dawn of the new millennium. This has been replaced by high-end boutiques offering ecological gifts and home décor, juice bars, yoga studios, and day spas. In contrast, the southern part of the neighbourhood continues to be home to many poor and racialized people, new immigrants, and members of the working class despite the significant gentrification pressures that have been a present in the area since the 1970s.

Against the backdrop of the changing spatial problematizations of health laid out in the first section of the dissertation, I argue that the vital politics of space that has shaped

Parkdale into the 21st Century, and its northern part in particular, is not merely the sum of "neoliberal" individuals self-interestedly pursuing their own optimal health; nor is it a phenomenon that can be adequately understood in terms of the historical trajectory of the movements of a disembodied capital. Rather, it is a politics of space that places the question of the vital characteristics of human individuals, communities, and populations at its very core. As such, it should be understood in light of broader shifts in the biopolitical regime of governance associated with the move to advanced liberalism in Canada. In particular, the biopolitical responsibilization of health is a citizenship duty, in the name of the maximization of wealth and prosperity of families, communities, and cities. The identifiable increase in forms of wellness consumption and preventative alternative modalities of health provisioning such as yoga, nutritionists, and others therefore emerges as a crucial dimension of this responsiblization. For whatever else the mainstreaming of Complimentary and Alternative Medicine might be, it is also an important site where citizens can enact, and be seen to be enacting, the imperative of health (Lupton, 1995) in an advanced liberal society.

4.2 Research Steps

In pursuing a genealogy of key features of our current spatial imagination of health I retrace certain events in the development of health policy discourses, understood as a form of power that shapes thinking and acting in the world. The first is the shift from an epidemiological containment rationality of governing urban space in the early 20th century to the development of national public health insurance in the 1950s and 1960s, informed by a governing rationality aimed at the production of a national labour market and nation of capitalist consumers. The second is the critique of the limits of national public health insurance, which gave rise to the new public health movement of the 1970s and 1980s. The third is the critique of the new public health movement that emerged in the work of

population health researchers in the 1990s. These events form the substance of Chapters 2, 3, and 4.

In selecting these events and the policy discourses that gave them expression, I have relied on the existing academic literature. For example, in the case of the development of Medicare, I have relied on Malcolm Taylor's (1987) classic account of the "seven determinative decisions" that brought into being the specific set of programs that we call Medicare, as well as more recent contributions such as Gerald Boychuck's (2008) excellent comparative analysis of the importance of national territory and race in the development of Canadian and US systems, respectively. In addition, I refer to a 2012 collection edited by Gregory Marchildon, titled *New Perspectives on the History of Medicare,* among others.

In revisiting the events highlighted in these studies, the intention is neither to "rewrite" the history of Medicare or the new public health, nor to provide a superior account. The aim is instead to revisit it with a different set of questions that will allow the genealogy of our contemporary local and urban spatial imagination to come into view. In other words, I reexamine this history against the backdrop of contemporary discourses which normalize the view that health is determined by social and physical characteristics of the neighbourhoods in which we live, work and play in order to bring the novel features of this truth discourse about health into view.

Similarly, in Chapters 3 and 4, I look to the "re-invention" of public health between the 1970s and the population health critique that emerged in response to this in the 1980s and the 1990s. The New Public Health began as self-consciously radical political effort to re-define "health" as chiefly a matter of prevention and lifestyle management and, consequently, a viable space for increased individual and community responsibility (Labonté, 1984; Lupton, 1995). I trace this reinvention through its rearticulation in public policy at

various scales, including World Health Organization health promotion discourses, federal health and social policy, and health and public policy at the City of Toronto. This analysis allows us to see how, in the Canadian context, "health" has been rescaled from a national and nationalist project to a decidedly more local affair, tied in particular to the social and physical characteristics of localized environments, such as urban neighbourhoods.

Chapter 4 looks at the ways in which the vital characteristics of neighbourhoods are brought into visibility in new ways. It discusses the ascendance of a new truth in public health research and policy that understands neighbourhoods as determinants of health. This was made possible by the emergence of the discourse of population health originating in the work of the Canadian Institute for Advanced Research in the 1990s (Chödrön, 2015; Hayes & Dunn, 1998; Murray, 2015; Orsini, 2007; White, 2011). The population health paradigm was explicitly critical of the scientific naïveté of health promotion thinking and quickly superseded health promotion. A crucial distinction between these paradigms was that for the latter, health "risks" were conceptualized as being tied to behavioural habits formed in adolescence, whereas the former understood health risks in terms of neurological processes and early childhood brain development. Thus, for population health, the effects of stress on the brain were paramount, and the effects of stress on the developing brain of young children were especially significant. This had the effect of bringing neighbourhoods into visibility in new ways. The central aim of this chapter is to show how this biological-environmental link, or nature-nurture dynamic enters the mainstream health sciences, and then becomes an influential policy frame. This chapter shows how the local environment is brought into visibility in new ways at the end of the 20th century and into the 21st.

While population heath was not at the outset a distinctly spatial science, we see here how population heath—as a science for understanding health risks in groups of people

rather than individuals—rapidly became tied to the production of as-precise-as-possible maps of the social and physical characteristics of local spaces such as neighbourhoods. This was made possible by the joining together of population health techniques with the developing field of Geographic Information System (GIS) mapping and its increasing importance in social and human sciences applications. The chapter therefore closes with a discussion of specific mapping and ranking exercises and the organizations that have pursued them for social policy and programing purposes. It also shows how such exercises bring different neighbourhoods into official visibility in different ways.

Thus, the three key questions that shape the research and analysis presented in Chapters 2 through 4 are:

(1) What kind of problematization led to the event in question?

(2) Based on the problem so defined, what kind of knowledge about life and health is produced? What are the features or dimensions of its spatial imaginary?

(3) What kinds of subjects are assumed or produced in the document in question?

After tracing out a genealogy of expert modes of modeling and demarking space, I turn to an analysis of changing material forms in Parkdale in Chapters 5 and 6. In these chapters I ask: how are dominant modes of thinking about and acting upon the relationship between health and space taken up or contested in Parkdale? As such, the methodological tools change somewhat, to become more anthropological in their outlook. In order to understand the changing commercial landscape in north and south Parkdale, I draw on four main types of sources: (1) semi-structured interviews with health practitioners and business owners in the area conducted between March 2015 and July 2015 (see Appendices A and B for a discussion of the interview method and a copy of the interview questions, respectively); (2) documentary evidence and photographs pertaining to the current and past constitution of

the commercial landscape, such as business websites and archival business directory listings, with particular attention to the changing nature and quantity of health-related businesses on the main commercial streets of historic Parkdale; (3) media representations of the areas, including in *The Toronto Star*, and on-line blogs, such as *BlogTO*; and (4) personal observations of the areas made through notes and photographs.

In Chapter 5, I use these sources, first, to trace the emergence of the visibility of Roncesvalles as a neighbourhood that is distinct from Parkdale, which is produced relationally to it in ways which align with broader processes articulating strategic relationships between the vitality of human beings and the value of local spaces. In particular, I show how community organizations—and the Roncesvalles village Business Improvement Association (BIA), in particular—helped to produce spatial distinction along vital political lines, and does so by aligning with certain expert measures pertaining to space and health. Further, drawing on existing research on gentrification in these areas, (Mazer and Rankin, 2011; Slater, 2004, 2005; Teelucksingh, 2002; Wieditz, 2007; Whitzman, 2009; Whitzman and Slater, 2006), I situate the emergence of these practices in the recent historical context of neighbourhood change, with particular attention to the role of knowledge about life and health in these processes. In this way, I argue, we can see more clearly the ways in which the wellness industries are entangled with broader processes of social and spatial change.

Chapter 6, the final chapter, focuses on the changes in the landscape of the health and wellness services in Parkdale and Roncesvalles, and the place of CAM health services and health practitioners within this changing landscape. I draw on City of Toronto directory rolls and other archival evidence (i.e. media content) to show certain trends about what kinds of organizations are moving in and out of the neighbourhood. This highlights certain trends

of change in the local retail landscape, with an emphasis on the coming and going of health-related enterprises on the main commercial streets (i.e. Queen, King, Roncesvalles, Dundas, and Bloor Streets) in the neighbourhood area loosely contained by "Parkdale."

Drawing on semi-structured interviews conducted with CAM practitioners in the spring and summer of 2015, as well as targeted archival research, I document how subjective orientations to the entangled problematics of space and health both conform to, and at times, contest, the broader dynamics outlined in previous chapters.[5] I then document the contemporary health landscape in Parkdale and Roncesvalles and shows how, beginning in the 1980s and gaining significant momentum in the period since the year 2000, CAM organizations came to constitute a significant presence, with a concentration along Roncesvalles Avenue. This took place in a context of population growth in both areas, and income polarization between them (Hulchanski et al., 2010). In addition to a quantitative documentation of these changes, I show how they entailed specific qualitative changes of the forms of health related discourses and practices, as well as the types of health care and forms of health care organization available, with particular emphasis on new and emerging modalities. The conclusion to the dissertation offers a reflection on the implications of this research.

[5] For a more detailed discussion of the interview methodology and supplementary archival research, please see Appendix A on page 355.

Chapter 2
Spaces of Health: From Local to National

> We have endeavoured to keep before us at all times the goal of human welfare which should determine the character of both political and economic systems.
>
> — *Report of the Royal Commission on Dominion-Provincial Relations*, 1941
>
> A nation's wealth consists not only of structures, machines, inventories and resources, but also of its human capital, the productive skills, knowledge and creative genius of its people. It is the quality of its human beings, their energy, ability, attitudes, education and training which make possible the expansion of technological and managerial knowledge which increasingly yield economic progress in the modern world.
>
> — *Report of the Royal Commission on Health Services*, 1964

1. Introduction

As the above quotes illustrate, in the years following the Great Depression and, later, the Second World War health, welfare, vitality, and the productive energies of the population came to be seen as crucial to economic progress, and the development of Canada as a national entity and as a liberal, capitalist democracy. What we refer to today as Medicare was part of this emphasis. It's formation articulated large-scale public investments in "health", and social welfare more generally, as commensurate with and necessary for, rather than antithetical or antagonistic to, economic growth. Prior to the rise of Medicare and its institutionalization of state funded curative medicine, urban environments were key fields through which curative and preventative pursuits of "health" were defined and acted upon. However, the development of Medicare would privilege the curative over the preventative (Armstrong and Armstrong, 2010; Coburn, 1999), and subsume the urban within a new national imaginary. This shift was bound up with a broader realignment from classic to

welfare liberal modes of governing engendered, in part, by new forms of expert knowledge and wider changes in political struggles and conditions.

This chapter traces a broad arc in health-governing rationalities from an early 20th century focus on contagion containment focused on local spaces and the dangers of the urban phenomenon of "overcrowding" to a governing rationality that emphasized health as a fundamental component of the development of a national labour market. In tracing this arc, the chapter revisits the historical development of Medicare as a crucial aspect of how "health" came to be territorialized across a national and nationalist political imaginary. This imaginary would simultaneously emphasize the centrality of individualized biomedical care over and above consideration for the urban environmental factors that were the concern of early public health reformers.

The intent of this chapter is not to give a causal explanation of what happened and when in the establishment of Medicare. This has already been very well covered elsewhere (i.e. Boychuck, 2008; Marchildron et al., 2012; Taylor, 1987). Rather, the objective is to document the shifting political rationalities for the governance and investment in "health," with an emphasis on mutations in spatial and biopolitical logics. Ultimately, the events that produced Medicare as a legal and political reality, in addition to being a key achievement of Canadian welfare liberalism, re-territorialized "health" across national space. At the same time they positioned the lives and bodies of individual Canadians as the raw material for national development. They did so through a biopolitical rationality which responded to the local and intimate experiences of material deprivation and physical and emotional hardship. These rationalities hinged upon theories and practices that tied the bodies of the masses to the body of the nation through a logic of investment in vitality. In the political rationalities underwriting the development of Medicare as a key component in the shift from classic to

welfare liberal modes of governing, urban space became temporarily subsumed into the broader nationalist and territorial aims. While urban areas remained important, they tended to recede into the background of these logics. At the same time, the development of Medicare—and the eclipse of the urban with which it was bound up—traced the separation of clinical biomedical care from public health, defined in preventative terms. Whereas this distinction was not effective in the first decades of the 20th century, it took on increasing significance by the post-War period.

Building from sociologist and policy analyst Malcolm G. Taylor's (1987) landmark study of the public policy history of Medicare,[1] and political scientist Gerald Boychuck's (2008) analysis of the importance of Medicare in the territorial integration of Canada in the 20th century, I focus on a cluster of five political events through which public health insurance surfaced as a key national problem space for political action. These events include (1) Charles Hastings' study of "slum" conditions in Toronto and the subsequent argument for national health insurance as a means to manage the relationship between poverty and illness; (2) the Rowell-Sirois Commission (1937-1940) and the identification of urbanization and industrialization as unique governmental problems; (3) the presentation of a comprehensive plan for a national health program at the Dominion Provincial Conference on Reconstruction (1945-46); (4) the first national "Sickness Survey" carried out in 1950-51; and (5) the adoption of hospital and physician insurance the form of the *Health Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1964).

[1] Taylor's (1987) account traces the seven "determinative decisions" (p. xiii) that produced national public hospital and physician services. He argues that there were in fact 23 key decisions in total: 20 provincial and three federal. My own approach focuses on the discourses about health that emerged through policy events and discussions about the future of Canada as a federal state, and, later, about the health of Canadians as an important topic in its own right. Taylor's account has been instrumental in informing my choices of the events and discussions on which I focus.

I read these texts with three questions in mind. First, how was health defined as a spatialized problem to be solved and how did this change over time? Second, what benefits were to be gained by solving this problem so defined? Third, what implications for governance arose from these assumptions? In considering these questions we can see how the case for a universal curative health care system evolved between the public health reform of the early 20th century and the post-War publication of the Hall Commission, in relation to a specific national territorial imagination.

The main argument of this chapter is that in Canada the predominant political and policy discourses that favoured the development of national public health insurance took place around the problematization and subsequent eclipse of a distinctly "urban" understanding of problems of spatially concentrated, large-scale forms of material deprivation. This hints at the emergence of a new type of biopolitical rationality that tied "health" to national space first through the language of human betterment, and then to that of human capital.

2. Problematizing the City: Public Health and the Limits of *Laissez Faire*

In 19th century Canada, governments became involved in health either for the purposes of granting the right to practice a health discipline, such as allopathy or homeopathy (McNab, 1970; Torrance, 1998), or in the management of epidemics, through practices such as quarantine. In all other respects, health was understood as a strictly private, local, or familial affair. In Toronto, the first board of health was established shortly after the city was incorporated in 1834. This was made possible by the Upper Canada Government's passage of an act to allow for the establishment of Local Boards of Health in the wake of the 1832 cholera epidemic (Bator, 1980, p. 122; Toronto Public Health, 1982). For the next 50 years

the board was active only when there was an epidemic such as cholera to which it had to respond. As such, this public health institution's work was intermittent, functioning mainly in an advisory capacity (Toronto Public Health, 1982). In 1882, pursuant to the passage of the first provincial public health act in Ontario, Toronto established the position of Medical Officer of Health as a permanent position (Bator, 1979; Toronto Public Health, 1982). Dr. George Caniff was the first to take up the role. Under his watch a system of medical police and hygienic inspection was instituted (Bator, 1979; Toronto Public Health, 1982). Armed with the scientific basis and legitimacy of the recently verified theory of germs, Caniff and a staff of six medical "police" inspected the homes and yards of citizens, as well as dairy and food suppliers, in an effort to enforce sanitary measures such as the cleanup and disposal of various forms of waste and of privies.

2.1 Discovering the "Slum" in Toronto: Not Just a Local Problem

In the late 19th and early 20th centuries the population of Toronto expanded rapidly, in large part due to immigration. This fed the need for a labouring population in the development of a nascent national economy, but it also produced relatively large and spatially concentrated populations of materially deprived people in cities such as Toronto. It was in response to these challenges that, in the early 20th century, public health in Toronto developed into an active, expansive, and interventionist discipline (Bator, 1979; Lornic, 2015a, 2015b). Between 1911 and 1929, Toronto saw a major increase in public health activities under the leadership of its fourth Medical Health Officer, Dr. Charles Hastings. Hastings was responsible for implementing the pasteurization of milk and the chlorination of water, as well as for expanding the system of public health nurses (Lornic, 2015a). And, importantly, it was Hastings who confirmed the existence in Toronto of "the virulent breeding ground of destitution and disease: the urban slum" (Toronto Public Health, 1982).

The 1911 "Report of the Medical Health Officer Dealing With the Recent Investigation of Slum Conditions in Toronto, Embodying Recommendations for Amelioration of the Same" was prepared by Hastings, under his own initiative for the Department of Health, and published on July 5, 1911 (Hastings, 1911). The report had two main objectives: to ascertain whether "slum" conditions existed in Toronto and to make recommendations for their "amelioration." Hastings opened the report by crediting "various charity organizations, public-spirited citizens, and the press" for "arousing" public interest in slum conditions in Toronto, and prompting the scientific study (p. 1). The study itself consisted in the inspection of the yards and interior spaces of 4,696 homes in the "more congested districts of the City" (p. 3), of which six were identified. The search entailed an exhaustive, house by house documentation the city's poorest inhabitants and their living conditions, recording the number of people per dwelling, their age, gender, religion, and nationality, as well as the details of physical living conditions, including the number of rooms, the presence or absence of windows, the presence or absence of plumbing, the nature of construction materials used, and so forth (see Figure 2.1 below).

Hastings concluded that

> The following conditions peculiar to great cities are found to be present [in Toronto] to a lamentable extent: rear houses, dark rooms, tenement houses, houses unfit for habitation, inadequate water supply, unpaved and filthy yards and lanes, sanitary conveniences so-called which because of their condition or position, or for various other reasons, have become a public nuisance, a menace to public health, a danger to public morals, and in fact, an offence against public decency. (p. 4)

What Hastings called the housing problem was therefore the central issue that produced and image of the slum as "a hot bed for the germs of disease." He wrote: "[c]ommunicable diseases are infinitely more prevalent in slum districts," and that this in turn was fundamentally related to the problems of rent and overcrowding. "High rents mean overcrowding and overcrowding is one of the worst evils of the Housing Problem" (p. 20).

Overcrowding was connected to higher death rates and the spread of infectious disease; and, similarly, dark rooms and rooms without air circulation were tuberculosis "hot beds." Furthermore, because poor people generally could not afford the services of doctors, if and when they did, it was for the more advanced cases of infectious diseases like Scarlet Fever or diphtheria. Milder cases went unrecorded and unquarantined, with the result that "the infected people are mixing up with citizens in the large hotels, crowded street cars, crowded theatres, and public buildings generally, and hence become a menace not only to themselves but to the municipality generally" (p. 22). Thus, for Hastings the problem of poor housing was an injustice to those who had to experience it, but it was also a health threat to the broader community and an affront to the ideas of civilization and progress: "… what we have read of with disgust as having happened in cities of Europe in the Middle Ages, happens in Toronto now before our very eyes" (p. 5).

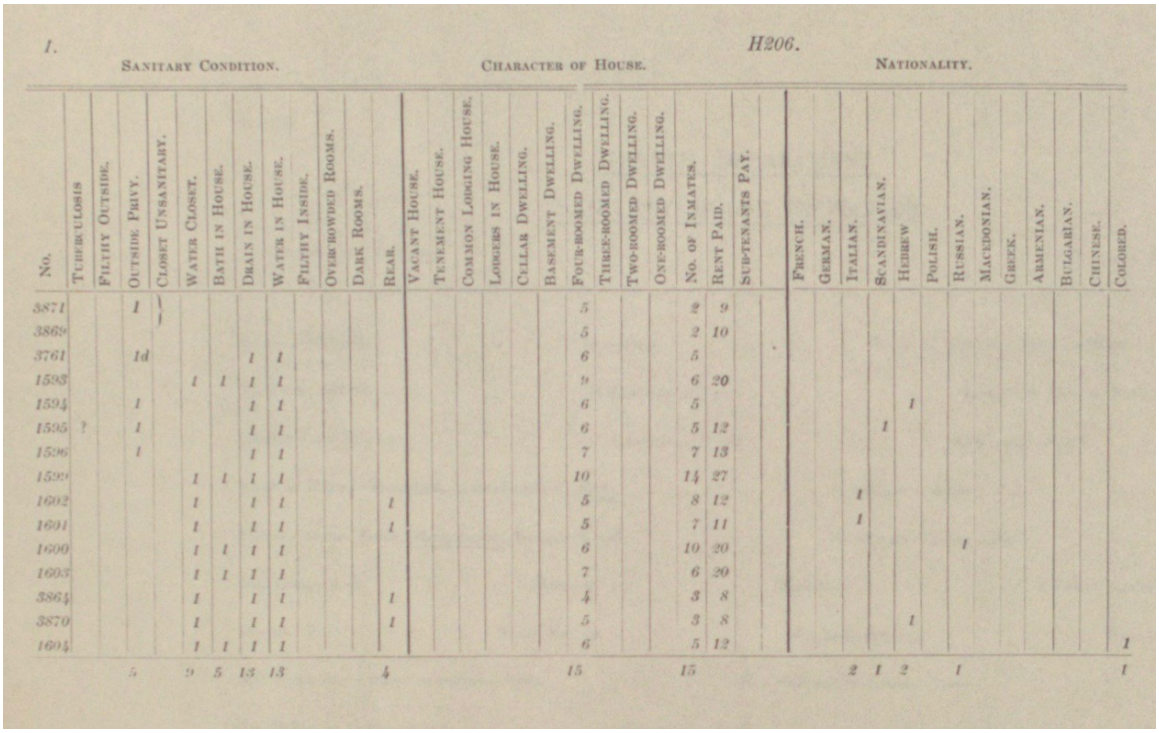
In this way the spaces of the domestic living arrangements and conditions of the working poor were articulated with reference to the health of the city as such. The institution of public health nursing, structured around the practice of visits to the homes of the city's poorer residents was particularly important in this regard. Hastings argued that nurses who went to a home, for example to monitor a specific case of tuberculosis, would also be able to assess the overall living conditions and health status of all residents.[2]

> The most outstanding example we have of the possibility of efficient [public health] education in this way is that in connexion with the control of tuberculosis. The nurses attend the tuberculosis clinics, and follow the patients to the home, instruct the people in the home as to the danger of contracting this disease, the danger of the spreading of it, how this danger can be eliminated, and how the one afflicted can be given the best chances of recovery and, incidentally, while visiting the home they ascertain the social conditions, as to whether or not the revenue is sufficient to supply proper and sufficient food, not only for the patients but for the other

[2] For this reason, inspections often took place at night so that the "real" nature of living arrangements could be properly assessed (Toronto Public Health, 1982).

> members of the family, in order that their resisting powers be properly maintained. (Hastings, 1917, p. 9)

This in turn would provide valuable information to the Department of Public Health, which could then intervene in a manner deemed appropriate. The nurses would also serve an important education function since the message of public health needed to be brought to "every man woman and child in the nation and… we have to deal with all degrees of intellect from the president or chancellors of our universities to emigrants who cannot read." The latter group, Hastings argued, "can only be efficiently educated by personal contact through heart to heart talks in the home, which can best be accomplished by the public health nurses who are visiting the homes" (Hastings, 1917, p. 9).



1. H206.

No.	Sanitary Condition.												Character of House.											Nationality.														
	Tuberculosis	Filthy Outside.	Outside Privy.	Closet Unsanitary.	Water Closet.	Bath in House.	Drain in House.	Water in House.	Filthy Inside.	Overcrowded Rooms.	Dark Rooms.	Rear.	Vacant House.	Tenement House.	Common Lodging House.	Lodgers in House.	Cellar Dwelling.	Basement Dwelling.	Four-roomed Dwelling.	Three-roomed Dwelling.	Two-roomed Dwelling.	One-roomed Dwelling.	No. of Inmates.	Rent Paid.	Subtenants Pay.	French.	German.	Italian.	Scandinavian.	Hebrew	Polish.	Russian.	Macedonian.	Greek.	Armenian.	Bulgarian.	Chinese.	Colored.
3871			1	}															5				2	9														
3869				}															5				2	10														
3761			1d				1	1											6				5														
1593					1	1	1	1											9				6	20													
1594			1				1	1											6				5							1							
1595	?		1				1	1											6				5	12					1								
1596			1				1	1											7				7	13													
1599					1	1	1	1											10				14	27													
1602					1		1	1				1							5				8	12				1									
1601					1		1	1				1							5				7	11				1									
1600					1	1	1	1											6				10	20							1						
1603					1	1	1	1											7				6	20													
3864					1		1	1				1							4				3	8													
3870					1		1	1				1							5				3	8						1							
1604					1	1	1	1											6				5	12													1
			5		9	5	13	13				4							15				15					2	1	2		1					1

Figure 2.1. Public Health Data Collection Instrument. Source: Hastings 1911, p. 33. City of Toronto Archives, Fonds 200, Series 365, File 14. Reproduced with permission.

Based on these observations and the analysis it engendered, Hastings put forth an argument for comprehensive planning aimed at the development of working class "garden city" suburbs, complete with a transit system to move workers back and forth from their

inner city employment, and a cooperative ownership model so as to avoid hindering the mobility of labour (Hastings, 1911). Planning for suburbanization was the key to solving the public health problems characteristic of slum conditions for two interlocking reasons. First, land in the areas outside of the urban core was significantly less "valuable," meaning that a worker could afford to rent or co-operatively own a single family dwelling on one fifth of his income (Hastings, 1911), thus leaving adequate resources for his and the rest of his family's healthy social reproduction. Second, the presumed availability of land meant that families could spread out into single-family dwellings with tidy, well-maintained yards, which, presumably, would eventually no longer need to be inspected. The suburban environment was thus the health-promoting antidote to urban overcrowding (see Figure 2.2 below).

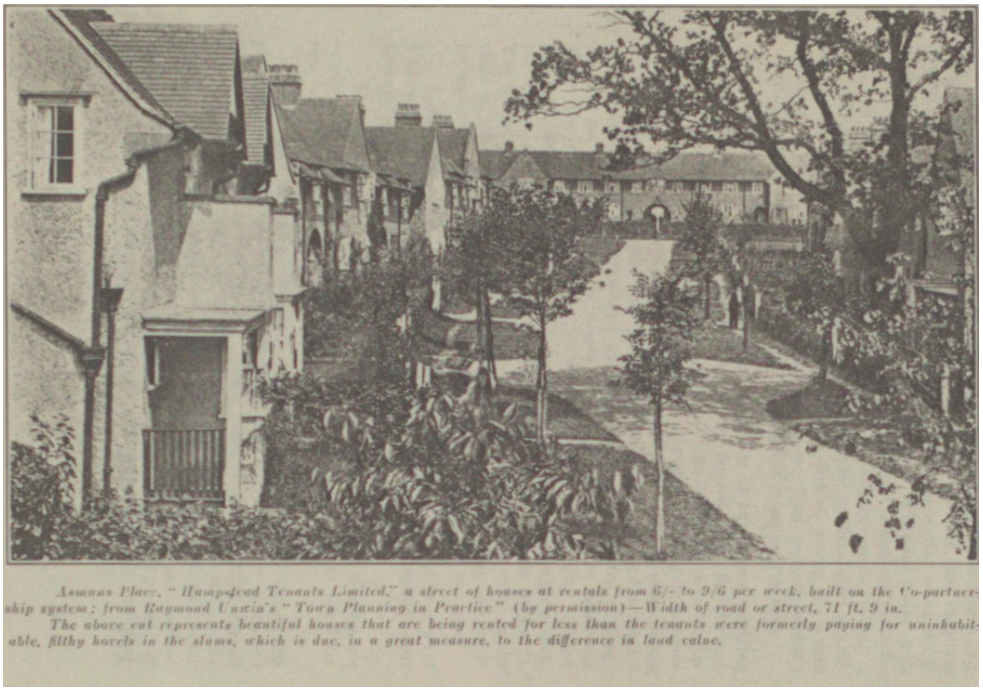


Figure 2.2: The Suburban Ideal. Source: Hastings (1911). City of Toronto Archives, Fonds 200, Series 365, File 14. Reproduced with permission.[3]

[3] The caption reads: "Asmuns Place 'Hampstead Tenants Limited,' a street of houses at rentals from 6/- to 9/6 per week, built on the Co-partnership system; from Raymond Unwin's 'Town Planning Practice' (by permission) – Width of road or street 71 ft. 9 in. The above cut represents beautiful homes that are being rented for less than the tenants were paying for uninhabitable, filthy hovels in the slums, which is due, in a great measure, to the difference in land value." (p. 27)

Hastings' report on slum conditions did not make a case for health as a matter of national concern, but he later developed his arguments for the "National Importance" of the administration of public health in a 1917 speech given at the 48th annual meeting of the Canadian Medical Association (subsequently published in the Association's journal, the *Canadian Medical Association Journal* (CMAJ)). Hastings argued: "the problems embraced in public health administration are federal–provincial and municipal. These are problems that governments must reckon with and that must take precedence to all others" (p. 703). Hastings compared the scale of deaths due to preventable illness to the loss of life in the "Great War", and stated that failure to prevent such loss of life was tantamount to criminal negligence on the part of governments. In making this case, his logic was not primarily one of social justice or human rights, though he did periodically invoke the "suffering and anguish" that accompanies the loss of life (p. 702). Rather, Hastings' primary argumentative strategy was to present an economic calculus to demonstrate that public health was a race-improving and nation-building (Valverde, 1991) investment in the biology and productive capacity of its workforce:

> This country is spending over one million annually to educate children who die from preventable diseases before they reach the age at which they could make any return to the government for the money that has been expended on their education. This is not good government, nor is it nation building. (Hastings, 1917, p. 703)

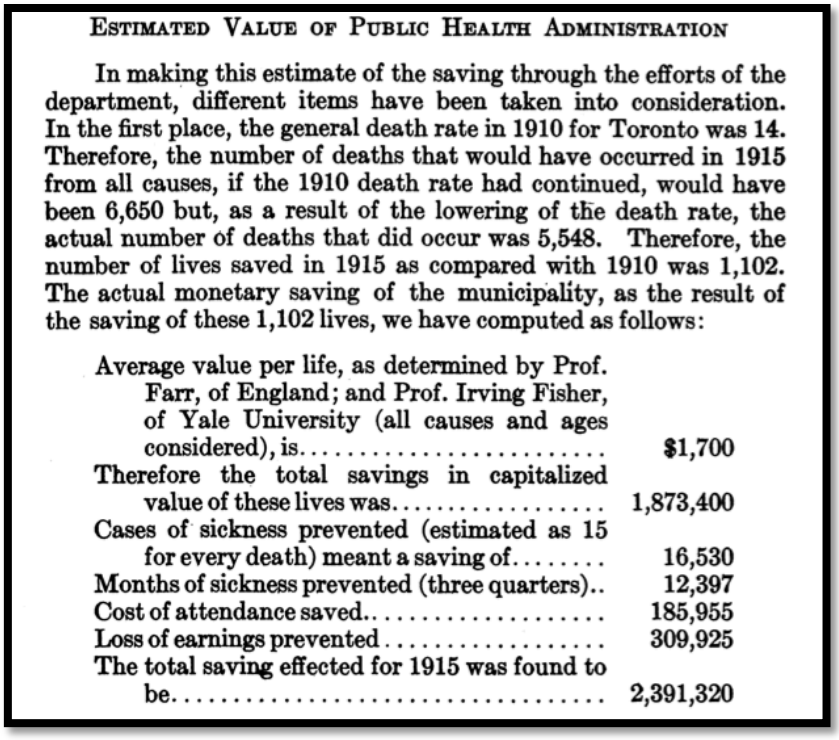
Hastings buttressed his argument with reference to the fate of the Roman Empire: "Rome had not realized that public health was a *national problem*… It was, obviously, not the Gauls and the Vandals that conquered Rome but the plague and malaria" (p. 687, emphasis added). In the context of the advances of modern biology, and the development of germ theory[4] in particular, Hastings argued that ignorance and superstition should not be tolerated.

[4] The theory that many diseases are caused by microorganisms and not by miasma, or "bad air", as had been previously thought.

"Through the science of biology we have acquired an accurate knowledge not only of the germs responsible for many of the disease, but also of their haunts and habits" (p. 689). Consequently, it ought to become apparent that methods for addressing illness needed to change accordingly. Moreover, in as much as it was possible for any municipality to safeguard its water supply and their milk supply through chlorination and pasteurization, he stated: "I unhesitatingly say that any community failing to do this is guilty of criminal negligence. Death from Typhoid fever or tuberculosis is practically murder or suicide" (p. 691). In order to combat the scourge of preventable deaths Hastings highlighted the following: (1) the importance of educating the public; (2) the prevention of premature death from causes other than communicable disease (especially infant mortality, "industrial disease," and the "degenerative diseases of middle life"); and (3) the expansion of government-sponsored health insurance.

For Hastings, it was paramount to understand that loss of life, whether in infancy or middle age, represented a loss of productive vitality and therefore a loss, in economic terms, to the development of the nation (figure 2.3). For example, he argued that unsanitary factories and workshops where characterized by dust, overheating, bad lighting, and improper ventilation, all of which "tend to lower vitality and, therefore the resistive powers of the body." With the resistive powers so weakened, the "individual is thereby rendered an easy prey to infection" (p. 695). This he saw as problematic, because it led to fewer days at work and contributed to the longer term weakening or degeneration of the human organism. Hastings argued that "no intelligent community or nation can afford long to disregard these degenerative diseases and their economic loss occurring, as they do, at the period in which life is most valuable, and in its most productive period" (p. 696).

Hastings understood health insurance to be a crucial component of the larger public health project. "Sickness and poverty go hand in hand, the one ever producing the other, and both are oft times closely allied to vice and crime…. Nations are realizing more and more every year the fact that the wage earning population depends, in a large measure, upon economic conditions" (p. 698). Therefore, "If we would have a sturdy, thrifty race, we must make it possible for them thus to develop. We have in health insurance an ally that points the way – a co-partnership of the employee, employer and the government" (p. 698). At the same time, public health insurance was conceived as a key complement to the local administration of public health, centred on the provision of safe milk and water supplies, and public health education, and the inspection of homes' yards, eating establishments, and dairies.



ESTIMATED VALUE OF PUBLIC HEALTH ADMINISTRATION

In making this estimate of the saving through the efforts of the department, different items have been taken into consideration. In the first place, the general death rate in 1910 for Toronto was 14. Therefore, the number of deaths that would have occurred in 1915 from all causes, if the 1910 death rate had continued, would have been 6,650 but, as a result of the lowering of the death rate, the actual number of deaths that did occur was 5,548. Therefore, the number of lives saved in 1915 as compared with 1910 was 1,102. The actual monetary saving of the municipality, as the result of the saving of these 1,102 lives, we have computed as follows:

Average value per life, as determined by Prof. Farr, of England; and Prof. Irving Fisher, of Yale University (all causes and ages considered), is	$1,700
Therefore the total savings in capitalized value of these lives was	1,873,400
Cases of sickness prevented (estimated as 15 for every death) meant a saving of	16,530
Months of sickness prevented (three quarters)	12,397
Cost of attendance saved	185,955
Loss of earnings prevented	309,925
The total saving effected for 1915 was found to be	2,391,320

Figure 2.3: "Average value per life": Calculating the Costs to the Nation. Source: Hastings (1917). *Canadian Medical Association Journal* (1917) 7(8), pp. 684-703. Reproduced with permission.

Hastings' social democratic and reformist ideas, which advocated for—and to a certain degree realized—a much greater and more active role for governments in the health of the population were in some ways out of step with the dominant classical liberal sensibilities of his day. But, while his vision for garden city planning in Toronto was not realized, his diagnosis of the "slum" helped to put public health on the national map. Moreover, his commitment to public health can be understood within the limits of the classical liberal sensibilities that viewed health as a strictly personal matter. In the face of the economic and demographic pressures wrought by industrialization and urbanization it became increasingly apparent that the geography of illness could neither be explained nor addressed from within such a viewpoint. As Murray (2004) explains, the breakdown of "long held traditions of rural and family life… paved the way for the emergence of a welfare liberal orientation of governing that hinged on the idea that a disciplined and ordered society could be promoted through targeted interventions in the lives of individuals and the economy" (p. 1). In the work of noted reformers such as Hastings, the problem of the health and vitality of the masses emerged as a distinctive spatial problem relative to the then-new phenomenon of urbanization. And, in turn, it gives rise to a political rationality with its own spatial logic: suburbanization. Furthermore, in the insurance idea, employers, workers, and the government could be imagined to be "partners" and not fundamentally antagonistic groups (Defert, 1991).

At the federal level, two main initiatives introduced health care as a key element in welfare liberal governing rationalities. The first was the Rowell-Sirois Commission (1937-1940) formally known as the Royal Commission on Dominion-Provincial Relations. Second, and following in its footsteps, were the "Green Book" proposals presented at the Dominion Provincial Conference on post-War reconstruction in 1945 and 1946. While neither of these

initiatives took health and welfare as its sole or even primary focus, both were crucial in making the case for the importance of *national* health and welfare, and in problematizing the then-existing constitutional status quo whereby health was understood as an essentially local and provincial matter of interest. They did this in two ways: first, by articulating linkages between nation building, national solidarity, and the health and welfare of the population; and second, by problematizing the lack of detailed, national-scale knowledge pertaining to the health of Canadians.

2.2 The Problem of Capitalist Urbanization in the Rowell-Sirois Report

By the 1930's pressure for greater state involvement in health care was coming from multiple sources. The worldwide economic crash had left a majority of Canadians struggling to meet the basics of life: food, shelter, and basic medical care. In this context provinces and municipalities, particularly in the resource and agriculture-based economies of the Western provinces, began experimenting with different modes of state health care provisioning for their citizens. For a brief period both organized labour and organized medicine were interested in seeing some form of state involvement.

By the end of the 1930s, the Social Credit government of Alberta, that of the Canadian Commonwealth Federation (CCF) in Saskatchewan and the Conservative-Liberal coalition in British Columbia, had all attempted to craft visions of state involvement in the provision of health insurance, albeit along different tracks (Marchildon, 2012; Marchildon and O'Byrne, 2012; Taylor, 1987).[5] Whereas in Alberta and British Columbia, provincial heath insurance bills were passed but never implemented in 1935 and 1936, respectively (Taylor, 1987, p. 6), in Saskatchewan, the Rural Municipality of Sarnia passed a law to allow

[5] Newfoundland's "cottage hospital" system provided state-paid services to the rural population beginning in 1936. This development therefore preceded, significantly, Newfoundland's entry into Confederation as a province of Canada (Lawson and Noseworthy, 2012).

for a salaried physician in 1915 (Huston and Massie, 2012, p. 139). This innovation opened the door to the subsequent enactment, in 1939, of the *Municipal Medical and Hospital Act*, which authorized municipalities province-wide "to raise personal taxes in addition to property tax to pay for hospital and medical services" (Marchildon, 2012, p. 7). By the mid-1940s there were salaried doctors on the payroll of 67 municipalities in Saskatchewan, as well as five in Manitoba and three in Alberta (Taylor, p. 6).[6]

It was in the context of the human suffering wrought by the Depression that the Rowell-Sirois Commission, named after the original Commissioners, Dr. Joseph Sirois (Chairman) and Newton Rowell,[7] came into being.[8] Appointed in 1937 by the newly re-elected Prime Minister, William Lyon Mackenzie King, the Commission was tasked with enquiring into relations between federal and provincial governments. Specifically, it was to undertake "a re-examination of the economic and financial basis of confederation and of the distribution of legislative powers in light of the economic and social developments of the last seventy years" (Rowell-Sirois, 1941, p. 12). And that its "opinion on these matters" should be expressed "subject to the retention of the distribution of legislative powers essential to a proper carrying out of the federal system in harmony with national needs and the promotion of national unity" (Rowell-Sirois, 1941, p. 13).

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[6] At this time, and in the decades to come, visions for what, exactly, this should look like varied widely. Key questions for individual provinces, as well as between the provinces and the federal government, included: Who would pay and through which kind of mechanism? Would insurance be voluntary or compulsory? What were the jurisdictional implications vis-à-vis the BNA Act? What would be the long-term financial and political implications for a province that decided to "go it alone"? Would a provincial payroll tax spell certain death for regional comparative advantage? (See Naylor, 1986; Taylor, 1987).

[7] Rowell resigned from the commission in 1938 after suffering a stroke. He was succeeded by Dr. JW Dafoe, who remained on the Commission until the completion of the report (http://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-2g03e.shtml).

[8] The commissioners were: Dr. Joseph Sirois, Chairman; Dr. JW Dafoe; Dr. RA Mackay; Professor HF Angus; Alex Skelton, English Secretary; and Adjutor Savard, French Secretary.

The Commission began by noting that in the 1860s and 1870s there was no federal governmental interest in the health of citizens, and, indeed, that there was no *need* for such an interest at that time:

> In 1867 the administration of public health was still in a very primitive stage, the assumption being that health was a private matter and state assistance to protect or improve the health of the citizen was highly exceptional and tolerable only in emergencies such as epidemics, or for the purposes of ensuring elementary sanitation in urban communities. Such public health activities as the state did undertake were almost wholly a function of local and municipal governments. (Rowell-Sirois, 1941, p. 33)

However, the Rowell-Sirois report argued, the events of the Depression had demonstrated the need for a change in this regard. In seeking to explain this event and the human suffering that it entailed, and to provide a rationale for increased federal government involvement in the welfare of citizens, the Rowell-Sirois Commissioners explained that what they called "large scale" social problems and human suffering were the unique problems of urban, industrialized societies. They argued that this was the first time in Canadian history that such problems had emerged on a *mass* scale: mass unemployment as well as "high rates of sickness and death, poverty, illiteracy and bad housing" (p. 10).

These novel conditions called for new thinking in regards to the legitimate extent of involvement of official institutions of power in the lives of citizens in general and in matters of health in particular. Fundamentally, the problem to be addressed was one of a shift from a rural, agricultural society to an urbanizing, industrializing one. Previously, the Commission argued, such problems were of a smaller scale and more localized nature. In rural, "farm village" communities, of which Canada largely consisted in the 19th century, "mass unemployment and mass destitution were unknown; welfare problems consisted of caring for weak or unfortunate individuals, rather than for large dependent groups." (Rowell-Sirois, 1941, p. 16) This was because "the care of the individual was a function of the family, which

because of its economic self-sufficiency, was ordinarily competent to carry the load as well as to meet the economic vicissitudes of the family group as a whole." Moreover, failing the "self-sufficiency of the immediate family group" there were, in the rural village context, others who could be turned to and relied on for assistance: "relatives, neighbours, private charity, or religious organizations" (p. 16). The welfare activities of the state were limited to occasional assistance in the form of relief for the poor by municipal or local authorities, and to the regulation of private charitable organizations (p. 16).

The Commission responded to its terms of reference by arguing that wealth inequality across classes and regions were the key threats to "national unity." In the novel context of mass unemployment, the Commissioners argued that what was needed "to promote feelings of unity and solidarity across the territory of the nation" was "not merely an expansion of the national income." Income had to be better distributed and "greater measure of social and economic security" had to be provided, both across the regions of Canada and across income groups. The problem of distribution was important, since both forms of inequality might, in the words of the Commissioners, "excite feelings quite… dangerous to national unity" (p. 7).[9]

Building on their analysis of the emergence of the new problem of mass society, the Commission warned against "thinking of national unity and of the federal system in the abstract as having some special merits which make them desirable in themselves." (Rowell-Sirois, 1941, p. 10) They argued instead that neither national unity nor abstract wealth were objectives in themselves. Rather, human welfare is the end that ought to be served vis-à-vis

[9] See Boychuk, (2008) for a discussion of the significance of national unity in the development of national public health insurance. In his account, national unity is first and foremost a regional concern for the federal government. In particular, Boychuk emphasizes the persistent significance of keeping Quebec within the federal fold. It is important, however, to remember that "national unity" was also very much related to class politics. The alienation of the "lower income groups" was seen as just as "dangerous" as regional alienation.

the interlocking tools of wealth creation and national unity. As such, one of the single most important tools or strategies for promoting national unity was the pursuit of the "higher aims" of political and economic community:

> In giving this special prominence to economic aims we have not been forgetful that any nation worthy of the name will have other, and in a sense, higher aims as well. Economic aims have of course a moral aspect, and crusading zeal to assail evil social conditions, high rates of sickness and death, poverty, illiteracy and bad housing, cannot be considered as crudely materialistic. But these higher aims are in no danger of conflicting with economic aims unless, of course, they are pursued with a reckless disregard for the necessity of maintaining the national income which is the long run essential for their achievement." (p. 10)

The Commission therefore insisted that it would be unwise to consider "economic aims" as ends in themselves. *"Any nation worthy of the name"* will have higher aims and will use their economic ambitions for moral ends, which include "assailing" sickness, as well as lessening "poverty, illiteracy and bad housing." Economic activity is not an end in itself; it serves the moral existence of the nation. At the same time, while there is some danger of conflict between "economic" and "moral" spheres, this is easily kept at bay, so long as governments do not behave "recklessly."

Accordingly, the Commission responded to its terms of reference by recommending the creation of unemployment insurance and old-age pensions as the most important actions that the federal government could undertake. It made these recommendations citing both the perceived intrinsic value of these services, as well as the legal and jurisdictional constraints of Canadian federation. And while the Commission clearly saw the need for increased governmental interest in the health of citizens, and the potential significance of health care within this realm, they were also careful not to make hard and fast recommendations:

> It must not, of course, be assumed that the Commission is in any way recommending the adoption of health insurance by the provinces. This is clearly a matter of provincial policy in which the province should have full discretion. The commission

> is simply concerned with pointing out that, if a province should desire to adopt health insurance the financial proposals made elsewhere in this report are not a hindrance…. We have concluded that two types of insurance – unemployment insurance and old age pensions – are inherently of a national character, but health insurance and workmen's compensation are not, and that in view of Canadian conditions, these can be financed and efficiently administered by the provinces. (Rowell-Sirois, p. 43)

Furthermore, even while the Commissioners listed a broad range of areas of current and future governmental interest in health, including food and water systems, workplace health hazards, and the cost of professional medical care, they did not see health as requiring centralized governmental control. In part this is because "health" and the tasks of producing health-related knowledge appear to be relatively straightforward. In Rowell-Sirois, "health" appeared to have been a self-evident category that required little study in its own right. The important places for the advancement of knowledge were in the study of medicine and diseases, and therefore should have been carried out through nationally funded medical research programs in universities (Rowell-Sirois, p. 35). The Commissioners argued that health insurance was in a sense less demanding of centralized responsibility or co-ordination when compared to other forms of social insurance, such as unemployment insurance and contributory old age pensions, because of its comparatively predictable and straightforward nature:

> Unlike unemployment insurance, health insurance is not subject to wide variations in demand; the risks are more easily estimated, and more constant. It is not subject to cyclical fluctuations, or sudden emergencies making widespread and prolonged drains on reserve funds…. We see, therefore, no insuperable obstacle to the establishment of health insurance by a province. (Rowell-Sirois, p. 42)

As such, Rowell-Sirois stopped short of declaring health as a field of governance that is "inherently of a national character." It argued that the dynamics of capitalist development, and capitalist urbanization in particular, would compel governments at all levels to become more involved in diverse matters pertaining to "health. The Commissioners did make some

brief and tentative remarks on the question of the probable increase in "the health activities of governments," expenditures for which were predicted to be on the cusp of rapid increase in Canada, "especially in the field of preventative medicine, and medical aid for the lower income groups (either in the form of state medicine and hospitalization, or health insurance, or both)" (p. 33). The Commissioners reasoned:

> The mobility of modern society due to the speed and ease of travel; the growth of urban and metropolitan communities; the interdependence of food and water supplies between widely separated geographical areas; the occupational diseases and physical hazards of high speed industrialized production; the loss of self-sufficiency of the family incident to the trend toward a wage earning society; these and many other social changes *have compelled governments at all levels to be concerned with the health of their citizens.* (Rowell-Sirois p. 33, emphasis added)

In the Rowell-Sirois report we see that capitalist urbanization and a growing dependence on wage labour were predicted to compel governments to take an interest in many facets of the health of citizens. On the one hand, the report naturalized the dynamics of capitalism and the catastrophic failure of markets as inevitable aspects of the progress of history. The capitalist production of wealth, signified through "industrialization" and "urbanization" were not, in themselves, questioned. They were simply identified as forces that produce the circumstances which (inevitably) require greater governmental interest and action. On the other hand, there was an assertion of human wellbeing as the raison d'être of the national political community. Thus, while the Commission did not recommend a constitutional amendment to allow the federal government to become involved directly in the provision of health services, health was clearly identified as a key site of nation building. The Commission said financial arrangements between federal and provincial governments "should not be a hindrance" to provincial initiative in this regard.

3. The Emergence of Health as a National Object

By the post-War period the health of the general populace was becoming increasingly identified in official discourses with the professionalized spaces of hospitals and clinics. This can be understood in relation to a few interlocking conditions. First, hospitals had become desirable places to treat and be treated for illnesses (Gagan & Gagan, 2002; Ostry, 2012). The growing acceptance and application of germ theory meant that hospitals had become safer places to undergo surgery or to give birth. According to Gagan & Gagan (2002), by the 1920s in Ontario, hospital-based treatment, once symbolizing poverty and death, came to be associated with progress, technology, and life. Accordingly, the upper and middle classes increasingly sought treatment there. Similarly, the advent of certain diagnostic and technical advances such as radiology and x-ray technology, as well as ongoing efforts to standardize both medical practice and education, meant that hospital practice and hospital-based teaching became more prestigious endeavours for doctors (Naylor, 1986; Ostry, 2012).

At the same time, the distinction between biomedical practitioners and "irregulars" became more institutionalized in the wake of the Drugless Practitioners Act of the 1920s, with the result that biomed achieved the apex of its dominance in the decades immediately following the Second World War (Coburn, 1999). In the late 19th and early 20th centuries the distinction between "alternative" and "biomedicine" was not yet institutionalized and normalized. Physicians, eclectics, homeopaths, and midwives went back and forth between being part of either the same regulatory college or of separate ones (McNab, 1970; O'Reilly, 2000). It was not until the 1920s, with the passage of the Drugless Practitioners Act, that a clear, and stable legal distinction between "regulars" and "irregulars" was carved out (Coburn and Biggs, 1986; Gort and Coburn, 1988). This nascent development of a medical monopoly saw the practice of alternative therapists and midwives either severely restricted or

outlawed entirely, thereby paving the way for "health care" to become singularly identified with the biomedical spaces of the clinic and the hospital. Similarly, with the medicalization of birth, childbearing came increasingly to be managed by men in hospitals, instead of in the home (Gagan & Gagan, 2002).

However, hospital-based care and diagnostics were expensive. Even with the combined fees of paying customers and government funds, voluntary public hospitals in Ontario had difficulty avoiding deficits (Taylor, 1987). Thus, with the advent of the Depression, both doctors and hospitals found themselves in increasingly challenging financial circumstances, because, on the one hand, patients were unable to pay for hospital and physician services, and on the other, families and communities struggling to meet their subsistence needs experienced sickness more often (Naylor, 1986; Ostry, 2012; Taylor, 1987). In this context, provincial medical associations tried to persuade their governments "not only to meet a more reasonable share of the costs [of medical care]," but also to put pressure on the Dominion government to include the cost of medical services in relief programs on the grounds that "medical care was as essential to survival as food, clothing and shelter in which the national government was sharing" (Taylor, 1987, p. 4). Similarly, in 1935, the Canadian Medical Association approached Conservative Prime Minister Richard Bedford Bennett directly to implore the federal government to take action towards covering the costs of medical care. Bennett steadfastly refused, insisting "the matters which you have presented are strictly the business of the provinces" (cited in Taylor, p. 5).

3.1 The 1945 Green Book Proposals

It was in the of the 1945 Dominion Provincial Conference on Post-War Reconstruction context that Mackenzie King put forward his government's "Green Book Proposals". The proposals were intended to convince the provinces to "go into partnership with the

Dominion in a broad programme for the development of our national heritage, and the promotion of the welfare of the Canadian people" (Dominion-Provincial Conference on Reconstruction, 1945a, p. 5)[16]. The goal was not realized at that time. However, the conference was significant in terms of shaping a framework for Medicare, as basic elements of Medicare legislation[10] were all contained in the 1945 proposals, including a vision for their comprehensive adoption.

The conference took place in Ottawa over the course of four days in August 1945. First Ministers of each of the nine provinces, as well as Prime Minister Mackenzie King and members of his cabinet, made deputations highlighting their visions for the post-War nation. The objective of the conference was to consolidate a post-War agenda of federal-provincial cooperation, wherein the provision of a "comprehensive system of social insurance" was marked as a key priority. Social insurance was imagined as a means through which the "purely selfish ends" of private enterprise on which the growth and development of the national economy depended, could be mitigated or softened:

> our proposals are designed to make possible a comprehensive system of social insurance, partially federal and partially provincial, through which the community will share with the individual in meeting the variations of income and expense to which the rise and fall of business activity, natural disasters, accident, ill health and old age render all of us liable. (Dominion-Provincial Conference on Reconstruction, 1945a, p. 6)

In this Keynesian countercyclical logic, the idea is that "liabilities" such as old age, natural disaster, and the contingencies of capitalist macroeconomics can and should pooled, with a view towards the negation of their worst effects. The investment in a social state in general,

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[16] In attendance for the provinces were all nine premiers: Thomas Clement Douglas (SASK), George A. Drew (ON), Maurice Le Noblet Duplessis (QC), Stuart Sinclair Garson (MAN), John Hart (BC), John Walter Jones (PEI), Alexander S. MacMillan (NS), Ernest Charles Manning (AB), and John McNair (NB). In attendance for the federal government were Brooke Claxton (National Health and Welfare), James Garfield Gardiner (Agriculture), Clarence Decatur Howe (Reconstruction), and Humphrey Mitchell (Labour).

[10] This includes, for example, the 1948 Hospital Construction Grant, the 1958 *Hospital and Diagnostic Services Act* and the *Medical Care Act* of 1966.

and in health in particular, is an insurance against the cost, in economic terms, of these "natural" inevitabilities. As King went on to explain: "[i]mproved standards of nutrition, housing, health, and social amenities, for both urban and rural populations, are also objectives of our reconstruction policy. Of these housing is a most urgent need in the period of reconstruction" (Dominion-Provincial Conference on Reconstruction 1945a, p. 6).

In the field of health, specifically, the 1945 "Green Book" proposals consisted of four elements, which broadly foreshadowed the structure and content of what was to be adopted in the 1950s and 1960s. These were: "(a) Planning and Organization; (b) Health Insurance; (c) Health Grants; and (d) Financial Assistance in the Construction of Hospitals" (1945a, p. 89). The planning grants were to be a first stage in a comprehensive plan, because they would allow the provinces to establish full-time health planning staff. In subsequent stages, health insurance would be adopted, with a priority given first to insurance for general practitioners' services as well as hospitals and services by visiting nurses. This would be followed in a second stage by a list of "other" services. These included: "other medical" (i.e. consultant, specialist, and surgical), "other nursing (including private duty)," as well as dental care, pharmaceuticals (including drugs and appliances), and laboratory services (p. 90). In addition to financial assistance in the construction of hospitals, the federal government also offered the provinces a system of health grants, which were divided into eight categories (pp. 92-94). These were: General Public Health; Tuberculosis; Mental Health; Venereal Disease; Crippled Children; Professional Training; Public Health research; and Civilian Blind.

King outlined seven key objectives, or "Desirable Features of a Plan of Health Insurance for Canada" to be achieved. First, it was to make high-quality health care available to the Canadian citizenry. Health care would be national in scope but adaptable "to meet the particular local conditions of the various provinces and should therefore be under provincial

administration" (1945a, p. 88). It should also be flexible enough that provinces could make use of health services and facilities that were already in existence. Next, it was to be capable of being introduced by each province in stages "in recognition of the fact that staff, equipment and administrative experience may be lacking for carrying out an over-all scheme immediately" (p. 88). Similarly, within a given province, it should be capable of coming into effect at different times in different areas if that province so desires. However, a time limit would be set for "complete coverage of the whole province." The national plan would outline what services were covered, but individual provinces would be able to determine specific methods by which such services would be provided, including arrangements with physicians, nurses, hospitals, manufacturers, druggists, specialists and suppliers of equipment. Finally, it was felt that "as far as possible, the existing personal relationship between doctor and patient should be maintained" (p. 88).

King echoed a sentiment articulated in the Rowell-Sirois Commission, stating the "problem of social security has two aspects. They are first, humanitarian or social, and second, economic or financial" (1945a, p. 88). Whereas traditional wisdom has been "prone to regard these aspects as conflicting" more recent thought had led to a realization that "broad social security legislation justifies itself, not only in humanitarian terms but in the contribution it can make to economic stability through the maintenance of production, income and employment, the equitable distribution of purchasing power" (p. 84). Whereas in Rowell-Sirois these objectives could be prevented from clashing through careful government management, in King's speech, it was not simply that economic and humanitarian goals could be prevented from clashing. Rather the contention now was clearly that health and welfare made a contribution of their own, by helping to maintain "production, income and employment." In this way, social security measures were imagined as a key means for

maintaining and enhancing domestic purchasing power, as a national aggregate. This in turn would help to ward off a repeat of the twin "economic" and "humanitarian" catastrophes witnessed in the 1930s.

In making the case for such broad co-operation in the pursuit of health and welfare, King invoked the sacrifices made by Canadians in wartime, and the need to reward these sacrifices with the promise of a brighter future. The reconstruction proposals were thus imagined as a way of assuring the population that the war had been more than a "defensive war against aggression" or to defend "our way of life on the level that it existed before the war" (p. 84). On the contrary, the proposals would fulfill a kind of promissory note, insofar as during the war Canadians had been "spurred on to maximum efforts" by the idea that out of it would come "protection to all the cherished freedoms won through centuries of struggle, and even more, that through it will come *a better way of life, a better chance at full and healthful living for common men and women everywhere"* (p. 84, emphasis added).

Here, there is broad emphasis on national unity and "maximum cooperation" between the federal government and the provinces to ensure that the "Canadian people, working together may achieve the constructive goals of peace as effectively as they have carried on the essential, though inevitably destructive, tasks of war" (1945a pp. 1-2). In addition to the objective of national unity, we also find phrases like "improving the national health" and "extending the benefits of modern science and medical care to all parts of the nation and all sections of the population" (p. 85). The goal of maintaining high levels of employment and income was the key strategy for achieving these goals: "Above all, we aim at the maintenance of a high level of employment and income. In no field are the interests of Dominion and provinces so thoroughly one that in the maintenance at all time of a high level of employment" (p. 6). These high levels of employment were to be achieved by

cultivating an environment in which private initiative and investment could flourish: "If we are to maintain a high level of employment and income in the period of reconstruction, the action of government – and by government I mean all governments, provincial as well as federal – must be such as to increase, not to decrease, the opportunities for individual freedom and initiative" (p. 6). However, King continued, "freedom and initiative must not be directed to purely selfish ends. These great qualities must be harnessed in the service of the community…" (p. 6).

Whereas the Rowell-Sirois Commission had stopped short of a definition of health as "inherently national," Prime Minister Mackenzie King articulated the goal of "improving the national health" and "extending the benefits of modern science and medical care to all parts of the nation and all sections of the population" (1945a p. 85) as key goals for a post-War partnership between the Dominion government and the provinces. The question is no longer how to not have jurisdictional issues be a "hindrance"; now, it is about imagining an active partnership, which will have as its objective raising the level of health and access to scientific medicine for the Canadian population. This had the effect of territorializing health across national space.

Also, by the time of the 1945 conference, the problem of a lack of knowledge about the health of the population emerged more fully than at the time of Rowell-Sirois. This was in part a consequence of the Second World War and the fact that surprisingly large numbers of military recruits were rejected due to poor health (Mosby, 2014; Taylor, 1987). This brought the question of the health of the population into visibility with new clarity and urgency (Taylor, 1987). In the conference proceedings and accompanying Health and Welfare Reference Book there are many references to the fact that the data available at that time for understanding and analyzing the health of the Canadian population were sparse and

inadequate. For example, in a discussion of "general public health services" it was noted that "morbidity statistics are not sufficiently complete to use as an index of the effectiveness of public health measures." (Dominion-Provincial Conference on Reconstruction, 1945b, p. 7) Thus the authors had to estimate based on mortality indicators alone to "some indication of the results achieved." This is further complicated by the fact that mortality statistics have only been available "for the whole of Canada only since 1921" (p. 7). According to the conference proceedings, the possibility of other vital indicators, such as life expectancy at birth, are further restricted by a lack of historical data: "Since the expectation at birth was not calculated previous to 1931, it is not possible to make comparisons for the country as a whole over an extended period of time."(p. 7)

Nevertheless, it was still both necessary and possible to estimate the cost of illness nationally, and the Advisory Committee on Health Insurance did so. Based on an estimated "average rate of sickness" of 7.65 days per person per year the "total cost of illness" in 1938 "would have been $264 million." Moreover, in addition to the "total cost of illness" there were costs in "lost in wages and other income" to be taken into account. "On the basis of the population distribution of the Census of 1931, this was estimated, in 1938, at $84 million…" (Dominion-Provincial Conference on Reconstruction, 1945b, p. 53).

The Green Book proposals were not successful in the immediate effort to adopt a comprehensive national program for the health and welfare of Canadians. In relation to health care, the sole federal measure to come in the years immediately after was the 1948 Hospital Construction grants program. The Green Book proposals offered a regional and class wealth redistribution mechanism capable of increasing national wealth by augmenting the purchasing power of working- and middle-class individuals and families, nationwide. The federal government made these proposals in exchange for taxation arrangements, which

would have extended the wartime powers of the central government. It was for this reason more than any other that the proposals for "a comprehensive health care system" were rejected in the mid-1940s (Taylor, 1987).

In the years between 1945 and 1955, the political and economic context for a discussion of a national health care program changed considerably. In the context of growing affluence, coupled with deepening polarization and suspicion around communist and socialist modes of governing, opposition to ideas of state medicine or state-sponsored health insurance grew in several sectors (Marchildron et al., 2012; Naylor, 1986). Most notably, these included organized medicine, the insurance industry, and hospital associations (Taylor, 1987, p. 108).

By the late 1940s the strength of professional medicine as an organized social and political group had grown considerably (Naylor, 1986). Whereas in the 1920s membership in the Canadian Medical Association (CMA) was sparse and thought was given to disbanding the association (p. 45), by the 1940s membership was growing steadily, and the 1943 Federal Special Committee on Social Security viewed the CMA favourably (Naylor, pp. 109-112).[11] Furthermore, during the Depression the economic situation of doctors was such that they approached Prime Minister Bennett to argue that health care should constitute part of the relief subsidized by the federal government, but by the 1940s physicians' average incomes were growing rapidly, and attitudes towards state-sponsored insurance changed accordingly (Naylor, pp. 151-152). In 1949, the CMA passed a resolution stating its unequivocal opposition to compulsory insurance and universal coverage. The 1949 policy supported the

[11] The Cabinet appointed a Special Committee on Social Security, pursuant to the urging of Ian Mackenzie, to consider the Heagerty Report and draft legislation of 1942, and keep the health insurance discussion "alive" (Naylor, p. 112). The Committee was to be all-party. Naylor (1986) writes: "Of fourteen doctors in the Commons, nine received appointments to the special committee. Other professionals comprised a third of the Committee's forty-one members. Seven members were successful businessmen. A sprinkling of farmers and Angus MacInnis – a Vancouver transit worker, CCFer, and son-in-law of JS Wooodsworth – rounded off the roster. It was not a body with whom organized labour or agriculture was likely to develop close ties" (p. 112).

extension of voluntary coverage, with state payment of premiums for those deemed unable to afford them (Taylor, 1987, p. 108). This represented a reversal of the CMA's previous stance, which was supportive of an insurance scheme so long as it were to be administered by "an independent party."[12] In other words, they had supported insurance in principle, but rejected the idea of public administration of it. For the CMA of the late 1940s two issues were paramount: state responsibility for covering only "low income and indigent groups" and a "clearly specified income ceiling on participation" in a public program (Naylor, p. 111).[13]

By the end of the 1940s and early 1950s there was also considerable growth in forms of voluntary insurance coverage, particularly in larger urban areas and areas with large industrial employers, due to the greater affordability of group coverage compared to individual coverage (Taylor, 1987, pp. 170-171). This confirmed for the hospitals and the insurance industry alike that the "free market" was capable of producing a level of coverage that would prevent a recurrence of the situation in the 1930s, when the necessity of providing free care and unpaid bills were more the rule than the exception, a situation which had pushed many hospitals and municipalities to the brink of bankruptcy (Taylor, 1987).

In addition to recovering faith in the market on the part of mainstream medical communities, a further complicating factor came from the fact that, at the end of 1948,

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[12] For doctors, a key point of contention hinged on the question of whether insurance should be "voluntary" and non-universal or compulsory and universal. For those supporting the voluntary side, those who could afford coverage would purchase as individuals or as groups, and those who could not afford premiums would be covered by a government plan. For those supporting the compulsory side, everyone would be covered by the same government-sponsored plan, with either premiums collected by the government, or paid for out of general revenue taxation. See Naylor, 1986.

[13] According to Naylor (1986), this set of policy preferences can be directly linked to the common, and from the physician's perspective, highly desirable, practice of price discrimination. Price discrimination is the practice of charging for a service what the patient is capable of paying, and not according to a set fee schedule. The policy option of state-sponsored insurance for low-income groups and private payment for higher income earners was the best way for physicians to insure that they could receive maximum possible payment from both income groups.

Mackenzie King resigned as Prime Minister and was replaced by the more conservative Louis St. Laurent. Unlike other prominent Liberals[14], St. Laurent had never been a proponent of state involvement in health insurance, taking the view that the federal government's proper role was the limited one of shepherding the national economy, not engaging in expensive social spending.

Aforementioned obstacles notwithstanding, there were other dynamics that would mitigate in favour of the eventual adoption of a hospital insurance act. In 1948 the Minister of Health and National Welfare, Paul Martin (Sr.) successfully persuaded Prime Minister King that "he should not end his long career without at least initiating the program of health insurance which had been for so long a stated liberal objective" (Taylor, 1987, p. 163). The program that came to be known as the Hospital Construction Grants Program was initiated in 1948: "'These grants,' said Mackenzie King at the time, 'represent the first stages on the development of a comprehensive health insurance plan for all of Canada'" (cited in Taylor, p. 164).

While voluntary insurance coverage had grown considerably in the immediate post-War era, there were several limitations to voluntary insurance that also became apparent over the period. First, coverage was geographically inconsistent, tending to be concentrated in areas of higher population density and larger employers (Taylor, 1987). Second, the content of coverage was not comprehensive in a way that was comparable to what had been imagined in the 1945 proposals. Particularly problematic was the fact that voluntary coverage was least likely to cover the full costs of the most difficult and lengthy (i.e. expensive) cases. Third, commercial coverage was more expensive than other forms of coverage, such as co-

[14] This includes, for example, Brooke Claxton, Minister of National Health and Welfare (1944-46); Ian Mackenzie, Minister of Pensions and National Health (1939-44); Paul JJ Martin (Sr.), Minister National Health and Welfare, 1946-57; and Mackenzie King himself.

operative-sponsored coverage. And fourth, by the early to mid-1950s enrolment rates were beginning to plateau (Taylor, 1987). All of this pointed to the fact that reliance on the market and voluntary coverage would not be a suitable way to achieve a goal of near universal coverage and comprehensive coverage. This in turn meant that voluntary coverage would be incapable of fulfilling the key governmental goal of a national health insurance scheme, as articulated in the Green Book proposals: a regional and class wealth redistribution mechanism capable of increasing the national wealth by augmenting the purchasing power of working- and middle-class individuals and families, nationwide.

Also by the early 1950s, four provinces—Alberta, British Columbia (BC), Newfoundland, and Saskatchewan—all had some form of state involvement in health insurance provision (Lawson and Noseworthy, 2012; Marchildon and O'Byrne, 2012; Taylor, 1987). This meant that there was a growing body of evidence that such schemes could work and be popular. The Saskatchewan plan, for example, was not only publically popular within the province, it was also place for the development of administrative expertise and experience from which other provinces could learn. Moreover, both the Saskatchewan and BC examples demonstrated, contrary to the fears of many, that public plans could be adopted without inflating costs above the rate set by the market for voluntary insurance in other areas, and with better coverage (Taylor, 1987).

3.2 The Canadian Sickness Survey: Making Illness Visible on a National Scale

At the time of Rowell-Sirois, the problem of health-related knowledge appears too straightforward to merit much mention, but by the 1945-46 Conference, the limits of then-current knowledge about the health of Canadians was being identified as a key problem space. The Sickness Survey both addressed the gaps identified earlier and pushed the problem of health knowledge onto a more sophisticated plane. In particular, the knowledge

gaps identified by the Sickness Survey had to do with (1) the lack of national data, meaning data collected on the national scale and through a uniform methodology; (2) the lack of historically comparable data, due to relatively recent advent of the collection of vital statistics; and (3) the insufficient detail that could be gleaned from vital statistics as a form of health knowledge.

The Canadian Sickness Survey was the first-ever national effort to produce knowledge about the health of the Canadian population and was divided into six sub-regions (Dominion Bureau of Statistics, 1960, p. 17).[15] The release of the preliminary results of the Canadian Sickness Survey in a series of 11 short bulletins between May 1953 and July 1957 provided policy makers and the public with scientific, national-scale data about the nature and prevalence of sickness in the Canadian population for the first time. Importantly, the data appeared to confirm a truth that had previously only been observed locally and/or anecdotally: that "Canadians were not a healthy people" (Taylor, 1987, pp. 5, 173). As such, the survey addressed a key problem identified by previous policy makers: the inadequacy of national and comparable data about the health status of Canadians (see Figure 2.4 below).

The 11 bulletins, which represented the initial release of data to the public, were not analytical in nature. Each one reported on a particular relationship between variables in the study, and touched on one of four areas. The first four bulletins dealt with various aspects of family spending on health services, the next three with aspects of what was called the "volume of sickness," the following two with the "volume of health care," and the final two with the frequency of illness. Other reports were issued using this data in the following decade, and in 1960 a comprehensive analysis of the data was published under the title *Illness and Health Care in Canada: Canadian Sickness Survey, 1950-51*. Thus, a limited amount of data

[15] These sub-regions were British Columbia, the Maritime Provinces, Newfoundland, Ontario, the Prairie Provinces, and Quebec. The Northern Territories were, quite literally, off the map. See Figure 2.5, below.

from the Survey was available by the time of the 1955 federal-provincial conference, with more data and more complex analysis becoming available over subsequent years, up until the appointment of the Royal Commission on Health Services in 1961.

The Survey took place over 12 months between the fall of 1950 and fall of 1951, during which time 10,000 households[16] from across the country were enlisted in the project of keeping records of their sickness events over the course of the year. The results of the survey were published in a series of preliminary reports between 1953 and 1957, and republished in a single consolidated volume in 1960. Lay enumerators were trained and visited each household in the survey once a month, plus once at the beginning of the study and once at the end, for a total of 14 visits per household. "All information, including particulars of income, housing and environment, was obtained by direct interview of a household informant, usually the housewife" (Dominion Bureau of Statistics, 1960, p. 17). In addition, households were left with a "special calendar designed to help the informant keep a detailed day-to-day record of current sickness and of expenditures on health care and services for each member of the household" (p. 17).[17]

In this way, not only was new information gathered at a scale and level of detail that had not been previously attempted in Canada, but some 10,000 citizens, mostly "housewives," became active participants in the collection and transmission of particular, detailed, and intimate information on the sickness and health care events and expenditures of

[16] There is an interesting discrepancy in the reporting of these numbers. While the Canadian Sickness Survey bulletins and reports themselves give the 10,000 number (see, for example, 1960, p. 17), later versions of this history record a much higher number: 40,000 (see Taylor, 1987, p. 173 and the Canadian Museum of History "Making Medicare: Canada Sickness Survey" http://www.historymuseum.ca/cmc/exhibitions/hist/medicare/medic-4c06e.shtml last accessed June 17, 2015). The truth is likely somewhere in between: Ostry (2012) gives a figure of 36,000 *persons* surveyed.

[17] The same description of the study and its methods appears at the beginning of each of the 11 Bulletins, as well as the 1960 report, *Illness and Health Care in Canada: Canadian Sickness Survey 1950-51*. The purpose of the 1960 report was to "reassemble" the "previously published data which were scattered in several reports." (p. 18). I cite dates on which data were originally made available.

their immediate family members. Similar to Hastings' public health inspections in the early 20th century in Toronto, the "official" visit to a domestic space formed a crucial node in the collection of health information. In this instance, however, the purpose was not to catalogue the precise spatial location of health threats or events. Rather, it was an attempt to produce knowledge about health events as well as certain forms of health expenditures (i.e. the form of health behaviour that is privileged in this exercise) in a way that could be generalized across national space and its six constitutive sub-regions. At the same time, and precisely because this knowledge needed to be abstracted across national space, the nature of the "details" or the knowledge gap to be filled was conceptualized differently: whereas Hastings wanted to record the details of physical space exhaustively for the clues and proof that this could yield about the conditions for spreading infectious disease and for unhealthiness more generally, the Sickness Survey sought, first and foremost, to fill a gap in the type of health event that could be recorded, tabulated, and compared. In both instances there was an effort to render heretofore "invisible" experiences of illness visible to the official gaze. However, the spatial tactics and assumptions were markedly different. "Detail" was not, in this instance, registered primarily on the level of the physical space, such as the presence of indoor plumbing, the number of windows per residence, or the number of lodgers per room. At the time, it was seen as most important to register the quantity of illness in terms of the number of days of productive activity that are subtracted from this nascent national totality.

Beyond illustrating, scientifically, that Canadians were "not healthy," this data and the reports based upon it made personal health and health consumption patterns on a national scale visible to policy makers, physicians, and ordinary Canadians for the very first time. Each report contained a simple truth about health and health care, rendered easily readable and digestible in tables, charts and maps representing the aggregate of people's

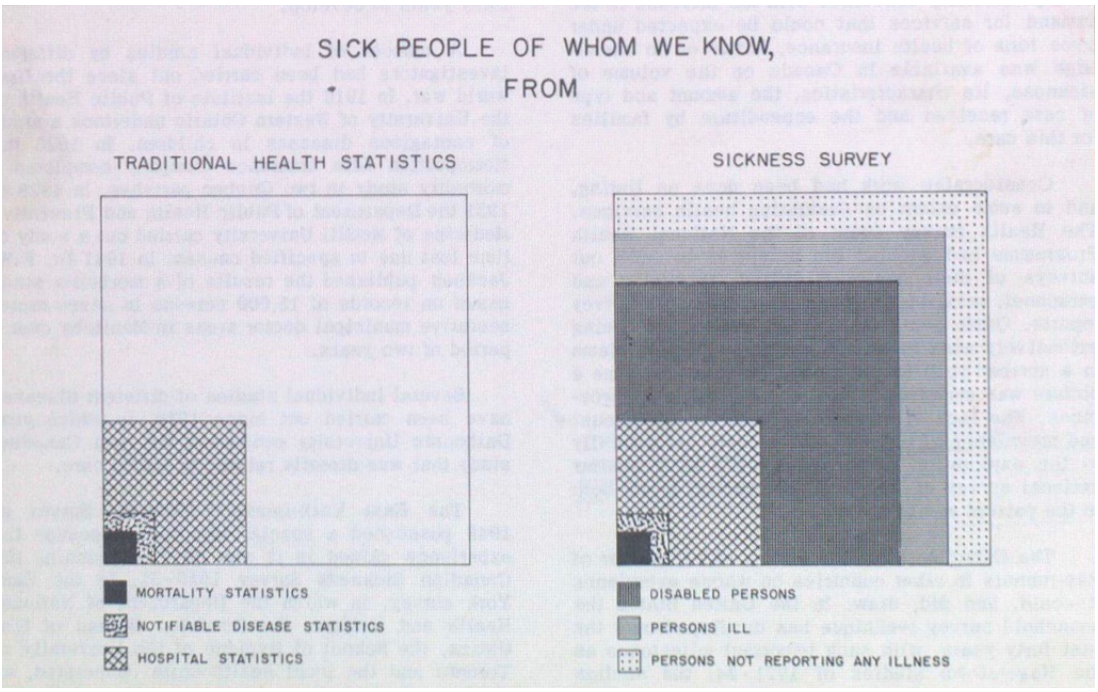

Figure 2.4 A Deeper Filling of the Pores of Knowledge: Traditional Health Statistics versus the Sickness Survey Source: Dominion Bureau of Statistics 1954b, p. 5. Reprinted under the authority of Statistics Canada Open Access License Agreement.

experiences of sickness and health care. In this sense, it also played an important role in defining what health was, and what the most important social, political, and economic questions to ask about it were. As Figure 2.4 suggests, there was a large void in health-related knowledge that was filled by the Sickness Survey by providing information on the relationship between three wholly new categories of persons or populations: "disabled persons," "persons ill, but not disabled," and "persons reporting no illness" (Dominion Bureau of Statistics, 1954b, p. 5).[18] These categories highlight the importance of labour market readiness, and not epidemiological concerns.

[18] "Disability" was defined by the Survey as a period of disruption to ordinary life "including bed rest, or care, which involves modification of the person's normal activity" (Bulletin no. 5, 1954, p. 5).

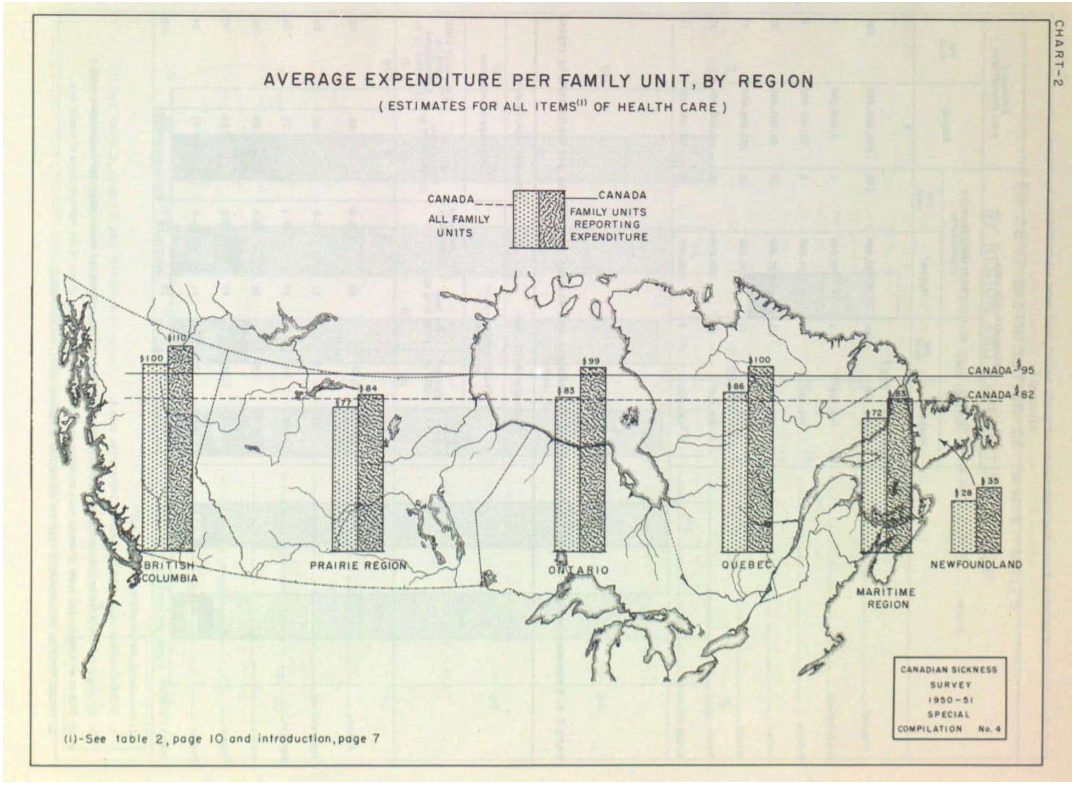

Figure 2.5: Making health care expenditure visible at a national scale. (Source: Dominion Bureau of Statistics. Bulletin no. 4, January 1954). Reprinted under the authority of Statistics Canada Open Access License.[19]

In particular, the first four reports, published between January 1953 and February 1954, showed clearly that health expenditures varied directly with income, with the lowest income households the most likely to be sick and least likely to receive care.[20] Later, in 1956[21] a bulletin was published which showed that the "low income" group was far more likely to be non-insured[22] (63.4 %) than the "medium" and "high income" groups (47.7% and 39.2 %, respectively). Moreover, low-income families were the most likely to purchase coverage through public plans, whereas the high-income group was most likely to purchase private

[19] Note that the North West Territories and the Yukon are not included on the map.
[20] Of course, people were responding to government enumerators and were therefore unlikely to report having sought forms of health care that were either illegal or simply unpopular or frowned upon.
[21] This bulletin, entitled "Volume of Health Care for Insured and Non-Insured Persons: Canadian Sickness Survey, 1950-51," was the first that I came across to exclude the word "estimates" (as in "National Estimates") from its subtitle, and from the text of the bulletin.
[22] Figures represent combined totals for those with hospital insurance and those with both hospital and medical insurance, through public not-for-profit, private not-for-profit, and commercial for-profit plans. Of the population, 1.1% was estimated to have medical coverage alone; this segment of the population was not included by the report authors in the above-cited numbers.

and commercial forms (Dominion Bureau of Statistics, 1954b, p. 5). This emphasis on income factors dovetails with Keynesian theories and the need not only to ensure labour market participation, but also to have citizens with adequate purchasing power to fuel national economic growth. Importantly, the geography of illness and care here is tied neither to particular urban spaces nor to an urban-rural divide. Rather, it is predominantly about documenting and addressing regional disparities (see Figure 2.5, below).

The Sickness Survey initiated a sea change, not only in terms of the quantity and the scale (national versus local and provincial) of data collected and made available, but also in the qualitative nature of the data that it produced. The data collected by the Sickness Survey was, for the first time, a concerted effort to record the personal health events and health consumption practices of individuals and families, and to aggregate this data into identifiable population groups based on income, "sex," and geography, in such a way as to be useful for large-scale health planning.

> In Canada, as in other countries the need for an accurate and comprehensive measurement of health conditions and problems had become increasingly apparent by 1950…. The lack of comparable data on the amount and prevalence of illness and its costs led naturally to the exploration of the possibility of a … national survey of illness itself and, its costs both to the patient and to the economy…. The Canadian Sickness Survey of 1950-51 was designed to obtain an overall picture of the health problems of Canada…. It tried to explore and bring together those areas of research which were not normally covered by the traditional series of health statistics. Traditional statistics of births, deaths, communicable diseases and hospitalization etc., did not view the field of morbidity as a whole. The Canadian Sickness Survey of 1950-51 provided statistics which helped in filling in the blanks on the picture of Canada's health. (Dominion Bureau of Statistics, 1960, pp. 15-6).

As Taylor (1987) argues, in the first half of the 1950s, the stage was "being set for some kind of major action" for reasons "more fundamental than the fact that the Liberals "had made a promise in 1919 and an offer in 1945 and now were required to follow through." On the contrary, information regarding "the health of Canadians, the unequal capacities of the provinces to cope with the provision and financing of health services, and, finally, the

pressures from the provinces already administering programs of personal health services" were all factors that compelled governments to act (p. 173).

3.3 Producing "Quality Human Beings": Medicare as Investment in the National Body

The two pieces of insurance legislation that made national public health care a reality were enacted between 1958 and 1964 in the changed climate of economics and information outlined above. An important moment came when Premier Leslie Frost of Ontario spoke out against Prime Minister St. Laurent, when he opened the 1955 federal-provincial conference by asserting that health insurance ought to be left off the table, suggesting instead that the "whole question be intensively studied" (1955, p. 18, cited in Taylor, 1987, p. 126). St. Laurent took the more classic liberal position that their meeting should be devoted strictly to economic matters.

> We believe that the proposals of 1945 are no longer suitable for our agenda in 1955…. our conference is most likely to succeed if we plan to consider only a limited number of subjects of primary importance…. The first… is that of future federal-provincial fiscal relations… and [the second] is the question of assistance to the unemployed. (St. Laurent, cited in Taylor, p. 106)

Frost, a Progressive Conservative by party affiliation and a fiscal conservative by policy persuasion, countered that to abandon such a discussion would be to abandon the noble cause of "human betterment." While Mr. Frost may have been no more ideologically disposed to the adoption of a large, expensive government-spending program than the Prime Minister was, he had other pragmatic concerns to deal with as well. Key among these was that even though there had been a significant expansion in voluntary coverage, Ontario hospitals were nevertheless in a precarious financial position at the time. Notwithstanding their partial support with provincial and municipal funds, by the mid 1950's Ontario hospitals were both lagging in bed capacity and running significant deficits. In Ontario in 1954, nearly one fifth of hospital revenues came from provincial and municipal governments

(Taylor, 1987, pp. 111-112). Yet, in those provinces that had ventured into public insurance (i.e. Saskatchewan and BC), hospital costs were rising no more rapidly than in Ontario. In fact, in BC, where the transition to public administration had been particularly rocky, costs had escalated less rapidly (p. 111).

Moreover, Frost clearly subscribed to the idea that "human betterment" through social welfare programs such as health insurance was the prudent choice for the growth and development of provincial and national economies. Frost also understood that the political climate in Ontario had to be carefully negotiated. The timing of an election in 1955 would be key, and both the Liberals and the CCF

> [c]ampaigned strongly for health insurance in 1951. With the Saint Laurent election strategy in 1953 that had transferred the onus for initiative to the provinces, it could be anticipated that both parties would emphasize that the most significant provincial decision would be that of Ontario…. From Mr. Frost's point of view the time might not be ripe for decision; but it was time to remove the blame for delay from his government and return it to Mr. St. Laurent and the Liberal Party. (Taylor, 1987, p. 116).[23]

Politically speaking, from Frost's position, pressuring the federal government to keep the issue open was the wise thing to do. As the provinces with the most to gain financially from the introduction of a federal cost-sharing program, Tommy Douglas (Sask) and RB Bennett (BC) supported him in this move.

Ultimately, it was the mix of pragmatic need and welfarist sensibility that won out, when, on March 25, 1957, Minister of Health and Welfare Paul Martin Sr. introduced Bill 320 to "authorize contributions by Canada in respect of programs administered by the provinces providing hospital insurance and laboratory and other services in aid of diagnosis" (Martin, cited in Taylor, 1987, p. 226). On May 1, 1957 the bill was proclaimed law and subsequently amended by the newly elected Diefenbaker government so that the *Hospital*

[23] Taylor produced a study of options for extending health insurance to Ontarians for Premier Frost in 1954.

Insurance and Diagnostic Services Act could come into effect as of July 1, 1958. As of that date, "five provinces – Newfoundland, Manitoba, Saskatchewan, Alberta, and British Columbia – had programs in operation eligible for federal cost sharing. Nova Scotia, New Brunswick, and Ontario introduced their programs on January 1, 1959. Prince Edward Island's plan began on October 1, 1959. Quebec's plan began on January 1, 1961" (Taylor, p. 226).

The *Hospital Insurance and Diagnostic Services Act* (HIDS), 1957, thus set the stage for nationwide physician insurance to become a reality. However, the eventual adoption of physician insurance was far from inevitable at this point (Boychuk, 2008; Taylor, 1987).[24] The HIDS had two key but opposing effects that would be important for the subsequent development of debates around the question of physician insurance. On the one hand, the advent of the HIDS as a cost-sharing program meant that the Douglas government in Saskatchewan now had the money to move ahead with the further development of its vision of a social state by moving towards the enactment of more extensive health insurance legislation (Taylor, 1987). On the other hand, movement towards physician insurance in Saskatchewan also had the effect of strengthening organized opposition to the possibility of a national scheme of physician insurance. As Boychuk (2008) writes,

> [W]hile it is often argued that the development of public medical care insurance in Saskatchewan set in motion positive feedback dynamics that created pressure for federal reforms, the political context for federal medical care insurance proposals in the wake of developments in Saskatchewan were not particularly propitious…. Organized medicine in Canada viewed the development of public medical care insurance in Saskatchewan as a 'serious breach.' (p. 127)

Accordingly, the CMA and various provincial associations dug their heels in, resulting, most famously, in the Saskatchewan Doctors' strike of 1962.

It was thus in a context of significant popular support and mounting professional opposition that the Royal Commission on Health Services was called together. Appointed in

[24] Of the Medicare Act of 1966, Gerard Boychuk (2008).

1961 in response to calls from the Canadian Medical Association for an "objective assessment" of the public insurance question, the Royal Commission on Health Services (hereafter, the Hall Commission) consisted of seven members, and was chaired by Chief Justice Emmett Hall.[25] The appointment of Hall, a conservative Supreme Court Justice and Saskatchewan native, was seen to have a little something for everyone: he was a fiscal conservative, unlikely to lean towards national health insurance for ideological reasons, and someone who also hailed from the same prairie roots as health care hero T.C. Douglas. In particular, Hall's reputation as a conservative with pro-free-market views, was thought to be the strategic choice, likely to appease the CMA (Taylor, 1987).

The Commission's mandate was "… to inquire into and report upon the existing facilities and the future need for health services for the people of Canada," and based on this, to make recommendations "consistent with the constitutional division of legislative powers in Canada, as the commissioners believe will ensure that the best possible health care is available to all Canadians" (Hall et al., 1964, pp. x-ix).[26] Based on this mandate, the Commission made 256 recommendations in three broad categories. The primary recommendation was that the federal government should enter into cost sharing agreements with the provinces and territories "to assist the provinces to introduce and operate

[25] The other members were: David N. Baltzan, MD (Saskatoon); OJ Firestone, PhD (Ottawa); Alice Girard, RN, (Montreal); M. Wallace McCutcheon, Esq. (Toronto); CL Strachan, MD (London); and Arthur F. Van Wart, MD (Fredericton).

[26] Additionally, the terms of reference included 12 specific items that were to be reported on, including: 1) the state of existing facilities and methods of improving facilities for health services, including prevention, diagnosis, treatment, and rehabilitation; 2) present and future personnel requirements, and training and qualifications methods for such personnel; 3) existing physical facilities and future requirements for such facilities; 4) existing and projected costs of health services rendered to Canadians, including costs of any suggested new programs; 5) existing methods of financing health care "as presently sponsored by management, labour, professional associations, insurance companies or in any other manner"; 6) methods of financing new or recommend programs; 7) the state of the relationship between medical research and scientific development and the existing and future health care programs, including methods for encouraging such scientific development; 8) the "feasibility and desirability of priorities in the development of health care services"; and 9) "such other matters as the Commissioners deem appropriate for the improvement of health services available to all Canadians" (pp. x-xi).

comprehensive, universal programs of personal health services" (p. 19). Such agreements were to take the form of grants, calculated according to a fiscal needs formula.

In defining what was meant by "comprehensive, universal programs of personal health services," six categories of services were listed: (1) medical services; (2) dental services for children, expectant mothers, and public assistance recipients; (3) prescription drug services; (4) optical services for children and public assistance recipients; (5) prosthetic services; and (6) home care services (Hall et al. 1964, p. 19). The remaining recommendations pertained to the "details and methods of developing this Program," and were divided into the three broad categories of recommendations: health services; health personnel, facilities and research; and financing and priorities. The Commission's recommendations for what ought to comprise a "universal, comprehensive system" were therefore much broader than what would ultimately be included in the *Medical Insurance Act* (1966) or the *Canada Health Act* (1984). The continued exclusion of public insurance for drugs, dentistry, and the inadequacy of home care services remain matters of debate to this day. While in this sense the recommendations appear "broad," in another sense, and relative to other contemporary debates around, for example, issues of housing, poverty, or environmental justice, they are left out of the discussion.

It is important to note the explicit and implicit exclusions that are articulated through the Royal Commission on Health Services. First of all, and of great significance in the context of more recent debates around the social determinants of health (Bryant, 2009; Mikkonen and Raphael, 2010), the Hall Commission explicitly excludes nutrition and housing from his discussion of how the health of the nation can be improved and invested in:

> Over the past quarter of a century… the probability that additional expenditures by Canadians on food, clothing and housing would yield significant benefits in the form

> of lower mortality or morbidity has likely declined while the probability of achieving a benefit from expenditures on medical, hospital, nursing, and dental services along with drugs has almost certainly increased. (Hall et al., pp. 505-506).

Significantly, this claim is made even while it is admitted that it was "not possible, at present, statistically to separate," and therefore to "know" with any accuracy, what contribution to reduction in morbidity and mortality was made by health services, on the one hand, or by necessities such as food, clothing, and housing, on the other.

In articulating the logic for why this vision of health care made sense as a national, tax-financed program, the Hall Commission reiterated themes familiar from earlier periods, such as those from the Rowell-Sirois Commission, Mackenzie King's remarks at the 1945 Conference, and those of Ontario Premier Frost in 1955: that health, as a form of social welfare has both "moral" or "humanitarian" as well as "economic" dimensions that must be considered. But here there is a difference as well. In the Hall Commission, economic and moral logics for the pursuit of a national health insurance program finally became fused in the discourse of human capital. Whereas once these things might have been seen as conflicting, they were now seen as compatible objectives, so that in the Hall Commission the need for a distinction between moral and economic life appeared to be trivial.[27]

In an interview on national public radio, Hall reiterates a key passage from the Commission's recommendations regarding the central idea of investing in human capital. In his introductory remarks in response to the interviewer's question, "why is universal health care important?" Hall explains:

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[27] In 1964 the Canadian Broadcasting Corporation aired a series of short radio segments aimed at dramatizing the debate over national public physician insurance, or "socialized medicine." as it was then pejoratively referred to. In one such segment, two men have a "water cooler" type conversation. One of the men is in favour of public insurance, the other fears it is a communist plot. Clearly, this drama reduces a complex terrain of debate to two simple, opposing ideological poles. But it is nevertheless instructive to look at the Hall Commission against this backdrop, first of all, because they are contemporaneous events, and second, because the intellectual course charted by the Commission does not align with either ideological pole. In brief, what the Hall Commission did argue was that public health spending was a—perhaps *the*—prudent investment in the economic future prosperity of the nation, defined in capitalist terms, as GDP growth.

> From the humanitarian standpoint there is, we believe, an obligation on society to be concerned with the health of its individuals. But on the economic side, investments in health are investments in human capital, just as investments in engines and railroads are investments in capital, so are investments in health. And they pay off, in the economic field, and they pay great dividends to a nation that looks after the health of its people. What we say is that society has an obligation to assist the individual to accomplish that which he by his own efforts cannot attain. (Hall, cited in Canadian Broadcasting Corporation, November 2, 1964)[28]

This passage reiterates for the radio-listening public the argument made in Volume I of the Commission's findings, in the chapter on "Economic Benefits of Health Services." Here, the Commission made a clear distinction between conceptions of capital as either "physical" or "human" capital. Addressing the broader question of whether health spending was an "investment" or only "consumption," the Commission reasoned that "If the objective of a society is economic growth, and economic growth is now defined not only as an increase in a nation's output but also as greater output *per unit of input* – increased productivity – then the question becomes what will lead to an increase both in output and productivity?" (Hall et al., p. 500 emphasis added). Against the backdrop of these assumptions about the "goals of society" and the meaning of "growth" in explicitly capitalist terms, the Commission argued, based on evidence drawn from submissions to their inquiry, that there were two distinct modes of thinking about capital. In the first case, "if growth takes place purely as a function of adding to physical capital, machines, buildings and inventories, then it may be implied that resources allocated to the production of health services are consumption and not investment and thus make no contribution to economic growth" (pp. 499-500). This, however, was not the only way of understanding and calculating how growth "happens":

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[28] CBC Radio *Farm Forum: A national health plan* [Digital archives]. Retrieved from http://www.cbc.ca/player/Digital+Archives/Health/Health+Care+System/ID/1809733378/, Last accessed, September 29, 2014

> if economic growth also depends on the *number* and *quality* of the population, then many non-material things, particularly health services and educational services may be classed as investments since either increase the supply of labour or improve its quality, both of which lead to a higher rate of economic growth and more consumption in the future than otherwise could be obtained. (p. 500)

As a massive undertaking of both documentation and argumentation, a crucial part of the Commission's core argumentative strategy was to argue that investment in health, in the form of tax-financed insurance, was effectively an investment in "human capital." The text of the first Volume of the RCHS begins by defining its "basic concepts," of which there are three categories: individual responsibility for health, the public interest in individual health, and public and group responsibility. The commission understands that individuals have wide latitude in determining their own health, insofar as they have the capacity to do so: "The commission believes that the individual is responsible for his personal health, and that of the members of his or her family is paramount to the extent of the individuals' capacities" (Hall et al., 1964, p. 3). Moreover, according to the Commission, research and professional opinion demonstrated that individuals have wide latitude in determining their own health status, particularly given that most infectious diseases had been brought under control. The reasons for public interest in health were identified as twofold. First, the growing humanitarian concern with the fellow man: "From the humanitarian standpoint there is an obligation on society to be concerned with the health of its individuals." Moreover, there was a need to recognize that the happiness of the nation was "merely the sum of the happiness of the individual citizens" (p. 5). The second reason was that there was growing awareness of the extent to which ill health was a "burden" on the nation. These burdens were at root financial burdens. Of particular concern was that the inability to work, or that

shortened periods of the life cycle when one could not be engaged in productive work due to illness, disability, and premature death, would impact the GDP.[29]

While investment in health would not relieve all of the cost burdens associated with ill health, such an investment would nevertheless be wise insofar as it would obviate the financial burdens associated with ill health. Thus, ill health was defined as first and foremost a burden on the nation and its economic progress, and not, for example, as a matter of individual or collective experience or suffering. In contrast, good health will produce a happy nation, where happiness is defined as material abundance and consumer purchasing power. Tellingly, of the Hall Commission's two stated reasons for investing in health nationally—economic and humanitarian—only the latter has a chapter devoted to it (Hall et al., pp. 495-520). There is no attendant chapter on the humanitarian or social benefits of health investment.[30] Presumably this is because economic progress self-evidently produces "happiness" and thus no separate or autonomous discussion of the matter is required.

Crucially, therefore, this understanding of health as human capital relegates the question of justice to the sidelines. Universally valuable social goods, it was presumed, would follow naturally. According to the Hall Commission, the ultimate reason for state involvement in insuring the health of Canadians was that this was a necessary and prior step in ensuring the wealth of the nation. Public debate at the time pitted a "free" (i.e. capitalist) market in health care against socialist state intervention. But Hall believed, and forcefully argued from a position of influence and authority, that in a capitalist society, the health of

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[29] In this sense the governmental "problem" is that people are now living longer and an ageing population is expensive to care for as it puts new "burdens" on the system, although these burdens are the outcome of the success of the earlier policy objective of extending the life span of Canadians so that they might be engaged in productive labour, in the service of the wealth of the nation, for a longer period of time. Now that this wealth has been so generated, the care of these people becomes a new governmental problem to be solved, and not a debt (to past life, past labour) to be honoured and paid.

[30] This thus gives weight to Boychuk's (2008) assertion that while "values" were at play, they should not be understood as the only, or the key determining, factors underwriting the politics and decisions to enact Medicare legislation.

the population—defined as the ability to work and to not be otherwise "dependent" on the state—is a capitalist investment of paramount import. In this sense, Hall's intellectual defense of state involvement in insuring health care is less an exception from his otherwise conservative, free market beliefs, and more a biopolitical vision for Canada's advanced capitalist future.

While the majority of the recommendations were never adopted (Boan, 2012, p. 293), according to historian PE Bryden (2012), the Hall Commission was especially crucial in impelling the Liberal Party, which had promised a health plan of some sort since 1919, to finally act. In 1963 and again in 1965 the Liberals, under LB Pearson, formed minority governments after having lost to the conservatives in 1957. This allowed tensions between conservative and reformist factions of the party to grow, around the issue of the Medical Care Act in particular. Such internal battles did not lend themselves to decisive action. Of this crucial juncture, Bryden writes: "Only one thing could push the Liberals into action, and that was the report of the Hall Commission. When Volume 1 was released in the summer of 1964, and, amazingly, advocated a government-sponsored system of full health insurance, the Liberals could sit on their promises no longer" (2012, p. 79).

The Royal Commission on Health Services was not only a key impetus to action; it was also a crucial milieu through which the "national interest" in health care would be defined, as would the parameters of "health" as a "public" responsibility. At the same time, the Hall Commission represented the first time a national, federal, stand-alone study into the subject of health care was pursued. Health therefore moved from being one of a broad basket of social goods that was discussed alongside and in relation to other measurers, to a topic meriting extensive study and consideration in its own right: "academics of that time [said] that it comprised the most comprehensive study of the health services of any country

that had been done up to that time" (Boan, 2012, p. 293). As health came to be an autonomous topic of major federal governmental study, so too was there a shift from an emphasis on the strictly technical basis of improving the health of the nation—through, for example, more and better medical research or increased spending on hospital construction—to a concomitant emphasis on social techniques such as the cultivation of right attitudes towards health consumption, in a context of universal health insurance coverage. The Commission therefore played an important role in carving out a particular understanding of "public" health care that implicitly left a much wider terrain of wellness beyond the reach of what was understood to be a public duty to health. At first glance this claim will seem counter-intuitive, as the Hall Commission is frequently, and correctly, cited for having recommended a broader and more comprehensive set of strategies for caring for health, including pharmacare and dental care for children and adults receiving social assistance (Boan, 2012).

4. Conclusions

Publically insured hospital and physician services, or "Medicare," is a cornerstone of the Canadian post-War social state, the battle for which is typically, and justifiably, understood as a "people's legacy" (Barlow, 2002, p. 7). This outcome was achieved gradually, over the course of several decades, and was also the result of protracted and complex political maneuvering, shifting alliances, and heated public debates (Boychuk, 2008; Marchildron et al., 2012; Naylor, 1986; Taylor, 1987). While it is possible today to refer to a single program, the constitutive pieces of the program evolved through the creation of three distinct pieces of federal legislation, passed over a 20-year period from the late 1940s to the late 1960s: the

National Health Grants Program, established in 1948; the Hospital Insurance and Diagnostic Services (HIDS) Act of 1957; and the Medical Care Insurance Act of 1966.

This chapter has revisited these events in order to show how they were bound up in the development of governing rationalities that emphasized health as a key component of the development of a national labour market. This rationality tended—at least temporarily—to supersede earlier health governing rationalities focused on containing the threats of contagion through the technical management of local space, and the spaces and living conditions of poor and working people in particular. In tracing this arc the chapter also shows how the historical development of Medicare was a crucial aspect of how "health" came to be territorialized across a national space and tied to nationalist political imaginary, which simultaneously emphasized the centrality of individualized biomedical care over and above consideration of the environmental factors that were the concern of early public health reformers.

The chapter has shown that there are three interlocking dynamics pertaining to the development of the federal government's interest and investment in the biological life of citizens (Foucault, 2003, 2007; Lemke, 2011). First, there was an increasingly confident and sophisticated intellectual apparatus linking the national health and the national wealth. Second, there was a gradual eclipse of interest in public health measures, in favour of a vision of improving the health of the population through widening access to individualized biomedical services. Third, there was a realization, which became apparent in the 1960s, that health was not merely an objective category of governmental action, but that it was also, equally importantly, a subjective and malleable site for governmental intervention *from a distance* (Foucault, 2007). In other words, by the time of the Royal Commission on Health Services there was a discourse on health that included a focus on how the population's

values, mores, interests and dispositions could and should shape a successful national health program. This discourse extended to how a successful national health program could in turn support the nation's development and prosperity. Moreover, the prospect of "massive" government "investment" in the health of the nation authorized, and made necessary, the concomitant governmental prerogative to cultivate a particular kind of political subjectivity vis-à-vis health, within the body of the citizenry. Finally, in the shifts that took place over this period, we see the change from the 1940s, when "human welfare" was articulated as the paramount objective of political and economic and community, understood first and foremost as national in scale (Rowell-Sirois, 1941, p. 10), to a modified notion of health as an investment in "quality human beings," and a productive input in the quest for an expansion of the national wealth, defined in terms of the Gross Domestic Product (GDP) (Hall Commission, 1964, p. 500).

Nevertheless, while the content of social insurance policies and proposals changed over time in ways that reflected shifting understandings of both of "health" and the boundaries of public responsibility for it, one more or less constant feature of the imperative to social security in general, and of health in particular, was the problem of income inequality, and the threat this represented to national unity and the national economy. However, at no time over this period were the challenges of meeting the need for adequate food, shelter, clothing, or health care evenly distributed across households: as the 1950 Sickness Survey confirmed, higher earning households experienced less illness, received more medical care, and were better covered under voluntary insurance plans (Dominion Bureau of Statistics, 1960). Thus, the most important aspects of knowledge about health and illness were identified with relative consistency as being class-based and related to regional distribution. Thus, the moral panic and humanitarian concern associated with these "social

facts" was directed disproportionately towards those individuals and households with the lowest wage-earning capacity; the bodies which it was most important to keep productive in paid and unpaid work through the techniques of health policy were the bodies of the poor and working classes.

The fact that urban space and urbanization haunted the biopolitical logic of investing in the health of citizens from the early days of the Depression-era Rowell-Sirois Commission is especially significant in light of later developments, which beginning in the 1970s, placed renewed emphasis on capitalist urbanization both as a problem and as a technique. Thus, notwithstanding the ongoing significance of hospitals in terms of the financial investments of governments, the emotional investments of citizens and the intellectual investments of scholars, this chapter also highlights some of the historical contingency of this development, as well as the relative historical brevity of the singular focus on hospitals.

Chapter 3
The "Darker Side of Progress"[1]: The New Public Health and the Rediscovery of the Urban

> Many would be surprised to learn that the greatest contribution to the health of the nation over the past 150 years was made, not by doctors and hospitals, but by local government
>
> —J. Parafit cited in "Healthy Toronto 2000" (1988).

> Ominous counterforces have been at work to undo progress in the health status of Canadians. These counter forces constitute the dark side of economic progress. They include environmental pollution, city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating patterns which put the pleasing of the senses above the needs of the human body.
>
> — Marc Lalonde, 1974

1. Introduction

In the 1970s and 1980s the theory and practice of public health as a local environmental issue was rediscovered and reimagined by governmental and health experts in Canada and internationally, in what was to become a major global policy phenomenon. The Lalonde Report, released as a green paper in 1974, was a key document in initiating this shift, which took shape around the idea of the New Public Health. The report represented a concerted effort to uncouple health and hospitals in the minds of the public, and to emphasize factors "beyond health care" that shape the health of Canadians. In deemphasizing the role of expensive hospital and physician care in improving health, the Lalonde Report focused broadly on the risks to, and mechanisms for, the improved health of the Canadian population, arising from three fields "beyond health care": environment, genetics, and lifestyle (1974). Within this emergent policy trend, cities were foregrounded as having a particular significance, both for the identification of environmental and lifestyle-related risks to health, and as sites through which the New Public Health could be

[1] Former Minister of National Health and Welfare, Marc Lalonde, 1974.

operationalized. The new urban spatial problematization of health that this represented therefore brought with it an imperative to generate new kinds of knowledge about cities and the kinds of health risks and opportunities that are proper to them.

Here, as in Rowell-Sirois, the urban contains a dynamic tension: on the one hand, it is highly valued and desirable as the spatial form of capitalist development and accumulation; on the other hand, it is in urban space and urban processes that the dislocations, inequities, and injustices of capitalism are most apparent. Thus, the Lalonde Report brought the problem of capitalist urbanization back to the foreground in relation to the biopolitical governance of health. However, the renewed visibility of urban space took shape in a markedly different set of circumstances. By the 1970s Canada was an increasingly urban society, governed by welfare liberal rationalities "that hinged on the idea that a disciplined and ordered society could be promoted through targeted interventions in the lives of individuals and the economy" (Murray, 2004b, p. 253). Thus, while Lalonde trained new attention on the urban, he did so in ways that problematized welfare liberalism by arguing that the "universal" program of entitlement to professionalized health care services had the unintended effect of producing passive subjects of health.

The Lalonde Report was significant in that it represented a key initial step towards the responsibilization of citizens for their own health and the health of their communities (Fusco, 2006; Lavernce and Lozanski, 2014; Lupton, 1995; Polzer and Power 2016). This is emblematic of a broad shift away from welfare liberal and towards neoliberal or advanced liberal strategies of governing (Rose, 1996). The discourse of health promotion also came to align in important ways with a shift within biomedicine from the treatment of disease to the management of disease susceptibility and therefore, ultimately, in creating

a key condition for the broad uptake of forms of self-care and preventative medicine associated with the rise of complementary and alternative medicine use that has been observed since the 1990s in particular (Barcan, 2008, 2011; Eisenberg et al., 1993; Ross, 2012; Tovey, Easthope and Adams, 2004).

In order to document these shifts, this chapter consists of two main sections. In the first I discuss the Lalonde Report and the conceptual innovations that it introduced relative to its problematization of the "sickness system" that Lalonde argued the curative biomedical health care system had become. The proposed solution to this was in the development and application of a "health field concept" aimed at broadening public and governmental understandings of what health is and how it can be achieved. This rearticulation consisted of a temporal shift, around the notion of "risk," as well as a spatial shift that displaced the centrality of the hospital in the imagination of what and where health is. These shifts were achieved by asserting the importance of "modern urban living" for future improvements to the health status of the Canadian population. In the second section, I discuss the reception of the Lalonde Report in the decades immediately following its release. In particular, I highlight how cities became sites where the imagined holism of the health field concept could be operationalized in the service of the new vision of health governance initiated by Lalonde. In Toronto, the New Public Health provided an occasion, first for a reevaluation of the aims and objectives of public health, and later, for municipal governance more broadly.

2. The Lalonde Report

The Lalonde Report was penned by then Health Minister Marc Lalonde in the latter days of Prime Minister Pierre Trudeau's "Just Society" mandate (Pope, 2012). Offered on the campaign trail in 1968, Trudeau's definition of the "Just Society" included a promise of protection for minorities against the "whims of intolerant majorities," full citizenship rights for Indigenous peoples, and a promise of broader inclusion of regions and groups who had not fully benefitted from the post-War economic expansion. In specific reference to the growing urbanization of Canadian society Trudeau stated, "The Just Society will be one where such urban problems as housing and pollution will be attacked through the application of new knowledge and techniques" (Trudeau, 1968). On the campaign trail Trudeau was also a vigorous defender of the newly enacted Medicare legislation.

The Trudeau administration came to power on a wave of optimism and in a context of economic prosperity. However, by the early 1970s the global economy had moved into a period of contraction and crisis. The decade was characterized by the historically novel situation of high inflation coupled with high unemployment, prompting the coinage of the portmanteau "stagflation." This situation was triggered in part by the 1970s energy crisis, which saw sharp spikes in the price of oil in 1973 and again in 1979 before beginning to fall in the early 1980s. Mainstream economists also attributed the novel correspondence of these previously opposing economic tendencies to the "price/wage spiral": as prices go up, wages tend to follow, especially in contexts where organized labour is a relatively powerful negotiating force. As wages rise, profitability falls, placing further downward pressure on employment. This analysis of the crisis in turn created conditions of legitimacy for what would become the familiar tenets of neoliberal

orthodoxy, which is oriented towards an economic solution that is defined as a restoration of profitability: financial deregulation, corporate tax cuts, and a concerted attack on organized labour (Harvey, 2005).

The combined effects of high unemployment and decreased tax revenues created significant burdens for governments in countries affected by the crisis. In Canada, this was further exacerbated by the fact that the federal government had recently embarked on a major new spending program. In 1971, Quebec became the last of the 10 provinces to sign onto the Medical Care Act. It was thus in the early 1970s that the full financial impact of the federal government's initial commitment to a 50-50 cost sharing agreement for Medicare became apparent.[2] In response to these various pressures, the federal government sought to redefine its cost-sharing relationship with the provinces for health insurance.

In June of 1973, the Department of Health (formerly National Health and Welfare) was tasked with producing a document to guide the development of a "new direction in health care policy" (Health Canada, 2009). The resulting document was entitled *A New Perspective on the Health of Canadians*, and was written by then Health Minister Marc Lalonde and presented to the House of Commons on April 1, 1974. Lalonde responded to this task by defining two key goals of the health care system: the first was formal health care, and the second was the promotion of good health through preventative mechanisms. He argued, at the time of writing, that the lion's share of emphasis had been on the latter, at the expense of the former.

[2] The *Medical Insurance Act* was signed by the Pearson government in 1966.

2.1 From Sickness to Health: Problematizing the "Sickness System"

The Lalonde Report was self-consciously "designed to shift the discussion in health and health care from the expensive funding of doctors, hospitals and illness care to illness prevention and the broader determinants of health" (Pope, 2012, p. 104). It began by observing the declining significance of infectious disease and epidemics in determining national morbidity and mortality rates in Canada, and sought to reintroduce a correspondingly updated vision of public health to guide health policy thinking into the future.

Central to this articulation of a new vision was a problematization of the limits of existing thought and action in the realm of health policy. Lalonde (1974) argued that the publically financed Canadian health care system had become a "sickness system" focused on treating illness rather than preventing it: "In most minds the heath field and the personal medical care system are synonymous" (p. 11). For Lalonde this was a much too narrow understanding of the health field: "The medical solution to health problems, while an extremely important aspect of health, is only one of many aspects revealed by an examination of the underlying causes of sickness and death" (pp. 25-26). In making the case for a new vision of health, Lalonde aimed first to destabilize the association of "health" with acute or "crisis" care and curative medicine; and, second, to broaden the work of prevention as the control of epidemics and contagious disease to include prevention of the late 20th century risks of chronic and non-infectious diseases. These new types of illnesses were to be the new targets of research and action. And, he further argued, in order to produce better knowledge and policy solutions, a distinction had to be made between "morbidity and mortality" and their "underlying causes." Such underlying causes were myriad, but could be broken into four broad categories using the "health field

concept." According to this concept, health care organization is but one of four major categories in the overall health field, the others being lifestyle, environment, and human biology.[3] Thus the health field was offered as a concept that called upon citizens and policy makers to think about health in its totality, in terms of all of the things that can be conceived of as "underlying factors" or elements shaping health outcomes.

Lalonde (1974) framed this epistemic shift in terms of a contrast between the "traditional view" and his "new perspective." The "traditional" and widely accepted view of the "health field," he wrote,

> is that the art or science of medicine has been the fount from which all improvements in health have flowed, and popular belief equates the level of health with the quality of medicine…. Individual health care, in particular, has had a dominant position, and expenditures have generally been directed at improving its quality and accessibility." (p. 11)

For Lalonde this view was out of touch with the realities of the modern world. He equated the "cure" orientation of medical care with an earlier epoch of infectious diseases. Lalonde noted that whereas in 1900, six of the 10 leading causes of death were infectious diseases, by 1970 "none of the ten major causes of death were infectious except pneumonia-influenza and certain diseases of early infancy" (p. 59). At the time of his time of writing, the major causes of death were "chronic illnesses and accidents, with relatively few due to infectious diseases. This was a drastic change from the situation around the

[3] Human Biology was said to included "the genetic inheritance of the individual, the processes of maturation and aging, and the many complex internal systems of the body… Health problems originating from human biology are causing untold miseries and costing billions of dollars in treatment services." Environment is "all those matters related to health which are external to the human body and over which the individual has little or no control." Lifestyle "consists of the aggregation of decisions by individuals which affect their health and over which they more or less have control." And Health Care Organization "consists of the quality, quantity, arrangement, nature and relationships of people and resources in the provision of health care...This fourth element is what is generally defined as the Health Care System" (Lalonde, 1974, pp. 31-32).

turn of the century when the major causes of death were primarily, or related to, infectious diseases…." (p. 22).

In diagnosing this problem Lalonde emphasized themes that echoed earlier discourses about health, such as the importance of health for "social progress." For example, he echoed the Hall Commission's ableist link between health, "happiness" and lives that are "worth living": "A nation of healthy people can do those things that make life worthwhile, and as the level of health increases so does the potential for happiness" (Lalonde, 1974, p. 5). However, Lalonde contradicted a major assumption of the Hall Commission. "The health care system." he argued, "is only one of many ways of maintaining and improving health. Of equal or greater importance in increasing the number of illness-free days in the lives of Canadians have been the rising of the general standard of living, important sanitary measures for protecting public health, and advances in medical science" (p. 5). Where Hall had assumed that the epoch of improvements in health outcomes from rising standards of living, nutrition, and housing would be surpassed by an epoch of health improvements through medical care and technical innovation, Lalonde sought explicitly to alter the kind of health thinking which equated health with health *care*: "It is evident now that further improvements in the environment, reductions in self-imposed risks, and a greater knowledge of human biology are necessary if more Canadians are to live a full happy and illness free life" (p. 6).

2.2 Problematizing the Passive Citizen: Population, Risk, and Urban Space

For Lalonde, the "sickness system" was problematic because it had come to represent an irrational and inefficient allocation of resources. Medicare had the unintended effect of "de responsibilizing" Canadian citizens, causing them to become passive recipients of "health," narrowly conceived in terms of the receipt of professionalized care. In effect,

Medicare had deresponsiblilized people for their own health. In the *New Perspective* (1974), citizens and policy makers were therefore encouraged to think of dimensions of health and wellbeing that lie beyond or outside of the health care system. The distinction between morbidity/mortality and their underlying causes was a key aspect of the change in thinking that Lalonde sought to provoke. This distinction was important because it would, in turn, allow for the accurate identification of risks in general, and "populations at risk" in particular, that were appropriate for the type of wealthy, urban, and industrialized nation that Canada had become since the birth of public health some 100 years earlier. These were epistemological shifts that needed to be introduced in order to guide policy, but also to shape the thinking of ordinary citizens. Lalonde took great pains to emphasize the overall importance of the concept of risk, as well as the importance of its being broadly understood: "it is essential that the concept of risk be understood because the application of the health field concept depends on it" (p. 39).

The necessity of changing attitudes towards health and, specifically, the need to cultivate a future-oriented and risk-averse Canadian citizenry entailed a reorientation of subjectivity *vis-à-vis* "the facts." Lalonde argued that a key problem to be overcome was Canadians' irrational uptake of rational knowledge. While "many Canadians by far prefer good health to illness" there was a limit to "the amount of immediate pleasure" they would sacrifice in order to stay healthy. "The behavior of many people also reflects their individual belief that statistical probability, when it is bad, applies to others" (1974, p. 9). This tendency to look only on the "sunny side of risk and probability" was, for Lalonde, irrational and problematic. Furthermore, it was a key, if unintended, effect of the development of Medicare: a false and overly narrow understanding of health field. This misapplication of knowledge about risk explains why "Canadians are prepared to spend

such a large part of their national income on personal healthcare services, while tolerating environmental and lifestyle hazards which contribute heavily to the frequency of sickness and death." Thus, a key aim of research and policy going forward should be to "show the links between different kinds of mortality and illness on the one hand and their underlying causes on the other." Canadians needed to be provided with this kind of information so that they might reproduce themselves as better, more risk-averse citizens: "Only when these risks are known will it be possible to make judgments on whether certain risks are worth taking, or certain sacrifices are worth making" (p. 9).

By definition, conventional age- and sex-differentiated mortality and morbidity statistics aggregate and express information about past health events (see Figure 3.1, below). The notion of an "at risk" population builds on this, but is also distinguishable from it, in that it extrapolates age- and sex-differentiated morbidity and mortality information into the future, in order to produce knowledge about which "populations" are most likely to experience morbidity or mortality from a given cause in the future. This knowledge can then be used to target specific health interventions towards specific populations. Accordingly, the necessity of inculcating a future orientation in health thinking in the Canadian citizenry at large was identified by Lalonde as a key challenge and objective:

> While it is easy to convince a person in pain to see a physician, it is not easy to get someone not in pain to moderate insidious habits in the interest of future wellbeing. Nor is it easy to make environmental changes which cause social inconvenience when the benefits of those changes fall unevenly in the population and are only apparent over the long term. The view that Canadians have the right to 'choose their own poison' is one that is strongly held. (1974, p. 5)

If current morbidity and mortality statistics show that heart disease is the leading killer among men between the ages of x and y, then this observation about the past will become

the basis for predicting the future, in terms of who is mostly likely, statistically speaking, to have a heart attack. In other words, if the state was to put itself in the business of lifestyle marketing, then it followed that knowledge should allow for as-precise-as-possible identification of target audiences/populations: which behaviours, exactly, need to be modified and by whom?[4] As Lalonde explains:

> For every statistical average in the health field, or in any social field for that matter, there are a number of 'populations' which contribute very unevenly to the average… In order to improve health conditions underlying a particular average, it is therefore necessary to sub-divide the contributing 'population' so that attention can be focused on that part of the population which is making the greatest adverse contribution to the average. This segment of the total population we call a 'population at risk.' (1974, p. 38)

Thus, we also see that a primary motivator in the drive to identify "populations at risk" is the desire to raise the national aggregate in health outcomes: the purpose of subdividing the population is to identify "that part of the population which is making the greatest adverse contribution to the average" (p. 39). This of course also means that these "populations" are identified as "threats" or "burdens" to the national body.

In these discussions of the notion of "at risk" populations, age and sex are the major analytical categories for delineation. This is evident both from the examples that Lalonde (1974) offered, as well as from the graphical presentation of data in Appendix A of the report, reproduced in Figure 3.1 above. The emergence of the notion of "populations at risk" as a new strategy for governing relative to conventional health and mortality data produced new ways of understanding and assigning meaning to conventional demographic categories such as age and sex.

[4] Lalonde's answer is overwhelmingly that those behaviours that involve drug, alcohol, food, and tobacco consumption, as well as a lack of exercise or "sedentary living," are what need most urgently to be modified.

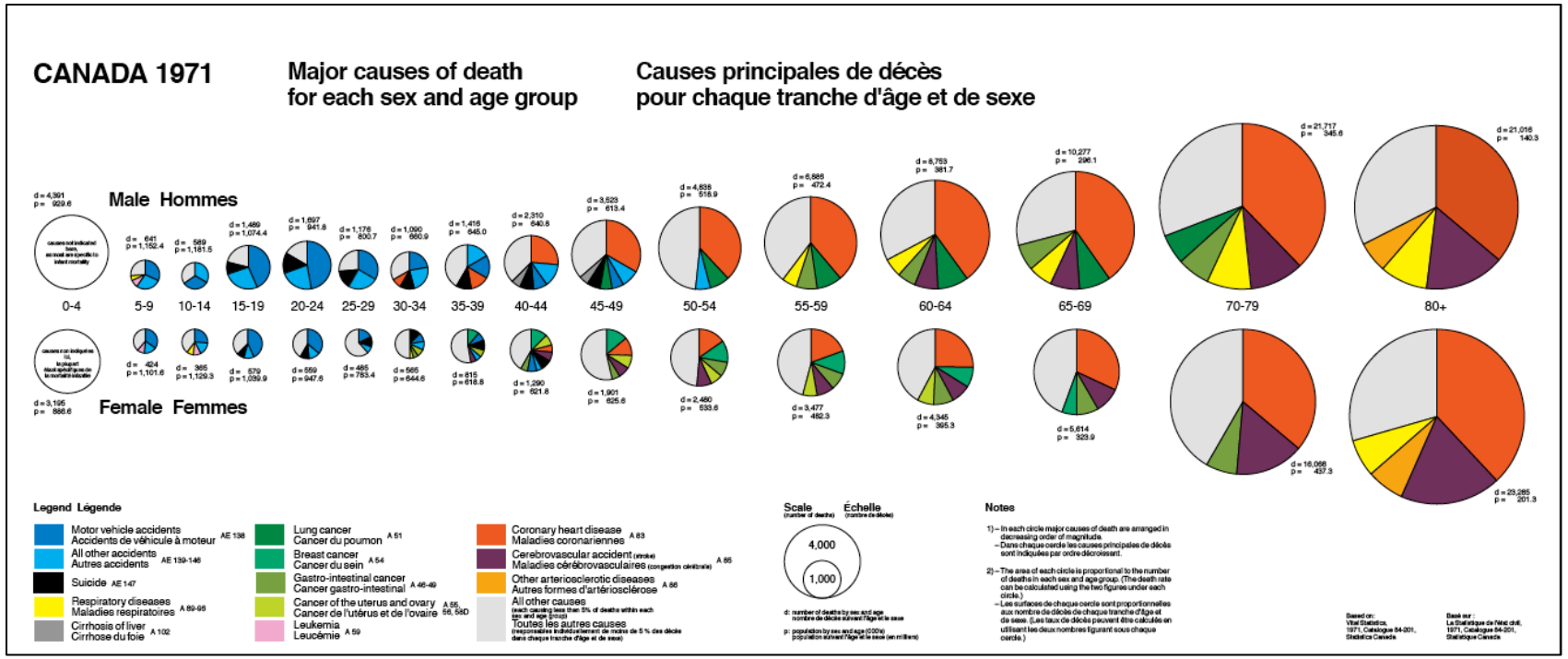

Figure 3.1 Visualizing Risk "Major causes of death for each sex and age group, 1971." Source: Ministry of National Health and Welfare, 1974. Reproduced with permission.

In the Lalonde Report, this is most apparent in the relationship between age and risk. Here, the notion of "age" takes on new significance and meaning as it is redefined from a synchronic category to a diachronic one: from "age at time of death" to a point in the lifecycle, which was determined by past life habits, chances, and risks. Thus Lalonde argues that the point in the lifecycle where one might first become "at risk" of cardiovascular disease or lung cancer is not in one's 30s, 40s, or 50s, but in childhood and adolescence: "some high-risk populations are readily identifiable, such as the 'candidates for coronaries' already described."[5] Some are more difficult, however, and "can only be identified by subtle analysis and insight. For example, when one measures the incidence of sickness and death among children aged 4-15 one finds that it is the lowest of any age group." But if one "penetrates" to "one more level of analysis… it will be found that these years are critical in the formation of habits and attitudes which are important to health, often for a lifetime" (p. 40). While adolescents are not "at risk" of coronary heart disease, they are "at risk" of making choices, such as taking up smoking, which will render them at risk of heart disease. Whether an adolescent takes up smoking or not is, for Lalonde, an expression of lifestyle, as well as an environmental factor. Thus, effective health governance will intervene in ways that minimize the lifestyle and environment-type risks associated with adolescent smoking.

These problems of time are also in some ways problems of space and scale. With the development of both a welfare state bureaucracy and forms of knowledge production capacities that span national space, planning, and provision for the health of the national population became possible in new ways. However, at the same time, the intimate link

[5] This includes, for example, men between 40 and 70 years of age, especially "an obese man who gets little or no exercise, ingests excessive amounts of animal fats, smokes cigarettes, drinks a lot of coffee and works in a high pressure job" (Lalonde, 1974, p. 39).

between specific bodies and their place and conditions of residence is no longer a key basis of health knowledge pertaining to the documentation and mitigation of "risk" as it was in the early 20th century. This gives rise to a new problem: how to get real citizens to identify their own lives and bodies with the abstract knowledge of risk that corresponds to a demographic group to which they currently belong, or might end up belonging to in the future, depending on factors grouped under the "lifestyle" and "environment" categories. The abstract nature of risk knowledge therefore poses a challenge which is only partially resolved through the technique of statistically tying specific risks to specific populations.

Thus the constellation of Medicare and non-infectious disease produced a new relationship between health, democracy, and citizenship, such that the relationship between a behaviour, a risk, and a population must be rendered knowable and acted upon at both individual and collective levels. Further, the notion of an "at risk" population, and the new citizenship duties it implied, were what distinguished health promotion from traditional, individualized medicine as administered in hospitals and by physicians.

> In dealing with risk one does not profess to make predictions about individuals but about the likelihood of an event occurring in a population with given characteristics…. Traditional medicine, as is proper, will tend to concern itself with treating the mortality-morbidity end of the spectrum while the course of action suggested by the Health Field Concept would be to focus on reducing the contributing factors in the population at risk, once that population had been identified…. In every case… the target is the high-risk population as opposed to the episode of individual illness, and the aim is to reduce the risks in that population. (Lalonde, 1974, pp. 39-40)

This is the crux of the meaning of Lalonde's most oft repeated assertion that the Canadian health care system had become a sickness system, and needed to be re-oriented to become a "wellness system." In this way, "wellness" and "risk" emerge as two sides of the same coin.

Lalonde's discussion of risk contrasted subtly but importantly with that of the Hall Commission, which said "It is clear that the well-being of a proportion of the population at any given time is seriously curtailed because of mental or physical disease, or impairment that, strictly by the laws of chance, could strike any one of us" (Hall et al., 1964, p. 5). The notion, articulated by Hall, that the laws of chance dictated that "any one of us" could equally be struck, is clearly at odds with Lalonde's argument that specific populations can be identified for specific risks, according to "the laws" of human biology, lifestyle, and environment. To be sure, Lalonde did not seek to replace the "insurance minded" system, which assured that "an individual family should not have to bear alone the full cost of risks that could happen to any one of us" (Hall, 1964, p. 5). He rather sought to alleviate some of the financial pressure on that system through risk management and wellness promotion, and by broadening the scope of our "insurance mindedness" beyond payment for "catastrophic" institutional care and into the realm of everyday life and bodily conduct. In other words, risk management, wellness promotion, and insurance mindedness would go together to create a more complete species of health and health policy thinking. Similarly, in contrast to public health in the early 20th century, when population density or "overcrowding" was a key threat conditioned by the spread of disease through contagion, the new threats of chronic illness were seen as related to behaviours and environmental conditions in new ways. On the one hand, the hazards of overcrowding and poverty harkened back to an earlier era of public health as the sanitary management of space. But, on the other hand, with the new emphasis on chronic illness, there was also new attention to notions of "lifestyle" and "environment." For example, whereas in the sickness survey, "environment" implicitly meant the household environment, the category was then expanded to include all conceivable aspects of one's

"physical and social environment." And so, the high standard of health care services in Canada notwithstanding, "there is little doubt that future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology" (Lalonde, 1974, p. 18). A key question, of course, is just what it meant to "improve the environment" or "moderate self-imposed risks."

For Lalonde (1974) urban space and the process of urbanization were central concerns, particularly for the lifestyle and environment categories of the health field concept. The health effects of urbanization were singled out as among the most important knowledge gaps, and, therefore, sites for future study and knowledge production. "Urbanization, and all its effects on physical and mental health, has not been assessed in any comprehensive way. Crowding, high-rise living, and the dearth of intensive use recreational areas in cities are all contributors to sickness in Canada" (p. 18). The economic expansion of the post-War period had not benefited everyone: "on the subject of environment, the number of economically deprived Canadians is still high, resulting in a lack of adequate housing and insufficient or inadequate clothing." These environmental conditions "create risks which are a far greater threat to health than any present inadequacy of the health care system" (p. 18).

The lack of opportunities for exercise built into the physical environment is one side of a coin producing passive citizens; on the other side are new technologies and modes of recreation: "the siren song of coloured television… [is] creating an indolent and passive use of leisure time" (Lalonde, 1974, p. 36). In addition to these aspects of the physical environment, the social environment of modern, urban life was also flagged as a crucial and poorly understood aspect of the health field:

> One of the most important but least understood environmental problems is the effect of rapid social change on the mental and physical health of Canadians. Some of the social change is due to technological innovation, such as the introduction of television, but significant disorientation and alienation arise as well from the crumbling of previous social values and their replacement by others whose long-term effect is still unknown. When a society increasingly pursues private pleasure by sacrificing its obligations to the common good, it invites stresses whose effect on health can be disastrous. (p. 36)

A further challenge to the cultivation of such a risk-averse citizenry was found in the temptations towards passive citizenship that accompanied certain aspects of "modern living" and technological advance. The "sickness system" contributed to the production of passive citizenship, because it deflected attention away from what ordinary citizens could do to promote and maintain their own health, outside of the formal health care system. This was further compounded by broader sociological shifts that were presumed to introduce new health risks or new forms of passivity: changing demographics meant people lived longer, the shift from a predominantly rural to a predominantly urban society, and new forms of work and leisure. Accordingly, Lalonde (1974) argued that both health care organization and the ordinary citizens' conceptualization of what health *is* had to change to reflect the new reality in which chronic illness was the most important health challenge standing between Canadians and their potential to live "full, happy, long, and illness free" lives (p. 6).[6]

The reference to overcrowding, high-rise living, and a dearth of spaces for the enactment of active citizenship (i.e. developing the body's forces and capacities through physical exercise) in the face of temptations towards passivity contained an implicit critique of post-War urban planning and its emphasis on large-scale housing projects. Urban space was supposed to be produced in such a way as to encourage health-seeking

[6] Drawing from the historical research of Thomas McKeown, Lalonde also suggested that the view that individualized medical care was responsible for the increases in life expectancy and other health indicators was ahistorical and that improvements in living conditions had been the most important factors.

behaviours. Here, we see that modern life came with many temptations away from good citizenship, that it was specifically and disproportionately "urban" in nature, and that the urban was both cause and effect of "crumbling" values. This highlighted urban space as an important site for health-related knowledge and policy production.

Yet the diagnosis of the passive citizen also raised a two-fold problem for liberal government. On the one hand, it was presumed that citizens needed to be convinced to adopt more prudential and risk-averse attitudes and modes of self-regulation, in a context of costly tax-financed "universal" health care. On the other hand, such a project appeared to fly in the face of the liberal value of individual freedom:

> The ultimate philosophical issue raised by the [Health Field] Concept is whether, and to what extent, government can get into the business of modifying human behavior, even if it does so to improve health. The marketing of social change is a new field which applies the marketing techniques of the business world to getting people to change their behavior, i.e. eating habits, exercise habits, smoking habits, driving habits, etc. (Lalonde, 1974, p, 36)

Lalonde (1974) raised the specter of propaganda and thought control, acknowledging "the dangers of government proficiency in social marketing" and acknowledging that his argument for an expanded notion of the "health field" was also implicitly an argument for an expansion of governmental interest in matters previously considered to be "private." Lalonde justified this on moral grounds, and asked whether the government did not also have "a duty" to market "programs aimed at promoting physical recreation" (p. 36). The phrase "even if it does so to improve health" therefore effectively positioned health at the limit of the liberal taboo on interference in the private lives of citizens. An expanded health field that tied the nation's vigour to the vigour of individual Canadians' bodies posed a distinct dilemma for a liberal rationality of individual freedom.

2.3 Holism and Public Policy: Towards "Healthy Public Policy"

Based on this this set of presumptive problems, the Lalonde Report (1974) emphasized the importance of adopting a "whole of government approach" to health promotion. Accordingly, Lalonde argued that the Government of Canada should

> give to human biology, the environment and lifestyle as much attention as it has to the financing of the health care organization so that all four avenues to improved health are pursued with equal vigour. Its goal will be not only to add years to our life, but life to our years, so that all can enjoy the opportunities offered by increased economic and social justice. (p. 6)

Thus the health field concept flagged these four key areas ostensibly to be given equal weight in a broad strategy of health promotion. Health promotion was to have two main goals: first, to "reduce mental and physical health hazards for those parts of the Canadian population whose risks are high," and second, to "improve the accessibility of good mental and physical care for those whose present access is unsatisfactory" (p. 66). In order to achieve this, five strategies were proposed, "in pursuit of these two objectives": (1) a health promotion strategy, (2) a regulatory strategy, (3) a research strategy, (4) a health care efficiency strategy, and (5) a goal-setting strategy (p. 66).

Lalonde (1974) acknowledged that jurisdictional issues arising from the character of Canadian federalism had the potential to hamper the effectiveness and uptake of health promotion. The "whole of government approach" he proposed was intended to navigate this challenge by showing policy makers that health problems did not respect or obey boundaries, and that all levels of government had a shared interest in promoting health. Lalonde wrote, "One of the main problems in improving the health of Canadians is that the essential power to do so is widely dispersed among individual citizens, governments, health professions and institutions" (p. 33). He argued that this "fragmentation of responsibility" had created a situation of "imbalance," one in which "each participant in

the health field pursuing solutions only within his area of interest" (p. 33). In consideration of his five-fold strategy of promotion, regulation, research, health care efficiency, and goal setting, Lalonde effectively argued that the weakness arising from fragmentation could be turned into strength, and that jurisdictional hurdles could be overcome by bringing the health field concept and the whole of government approach together. This would reconstruct the problem of health policy as "a unified whole which permits everyone to see the importance of all factors, including those which are the responsibility of others. This unified view of the health field may well turn out to be one of the [health field] concept's main contributions to progress in improving the level of health" (pp. 33-34). For example, with tobacco control, Lalonde saw a role for the federal health agency in regulating the production and sale of tobacco products, a regulatory role to be played by municipalities in enforcing no-smoking bylaws, and a promotion role to be played through education efforts. Other health problems were to be treated in a similarly "holistic" fashion.

Lalonde (1974) acknowledged that the health field was huge, and that the underlying factors that it sought to identify and address were myriad. But he argued the health field concept—composed of the four major categories of lifestyle, environment, human biology, and health care organization—made an important contribution in that it allowed "thousands of pieces [to be organized] into an orderly pattern that was both intellectually acceptable and sufficiently simple to permit a quick location, in the pattern, of almost any idea, problem or activity related to health: a sort of map of the health territory" (p. 31).

The reception of the Lalonde Report and its vision for health promotion was decidedly mixed. The Lalonde Report has been hailed by supporters as "the first modern

government document in the Western world to acknowledge that our emphasis on a biomedical health care system is wrong, and that we need to look beyond the traditional health care (sick care) system if we wish to improve the health of the public" (Hancock, 1985, p. 10). Critics pointed to the fact that it was moralizing, illiberal, and even hypocritical (Lupton, 1995; Orsini, 2007; Pope, 2012), as in the cartoon reproduced below (Figure 3.2). In her discussion of this cartoon historian Felicity Pope notes that it was published just before parliament was dissolved and Canadians went back to the polls in July 1974. We see here the point being made about the hypocritical and politically risky nature of telling Canadians to change their "bad behaviours" on the eve of an election. This critique was often repeated by those who pointed out that while Lalonde had mentioned environment, most of the emphasis was ultimately on lifestyles, as the report encouraged individuals and organizations to "accept more responsibility and be more active in matters affecting mental and physical health" (Lalonde, cited in McKillop Farlow, 1987; see also Coburn & Poland, 1996; Labonté, 1994, 1995). Lalonde's optimism regarding the whole of government approach notwithstanding, critics argued that health promotion was simply impractical, given the federal government's lack of jurisdiction in health-related matters (Boychuk, 2012; Crichton et al., 1997). Nevertheless, over the course of the 1980s the idea of health promotion gained steam, as did that of "healthy public policy," which emerged as a re-articulation of Lalonde's "whole of government approach." The former became a key idea in the development of health promotion in the 1980s, which focused attention on the urban milieu as the natural expression of this holistic approach to health.

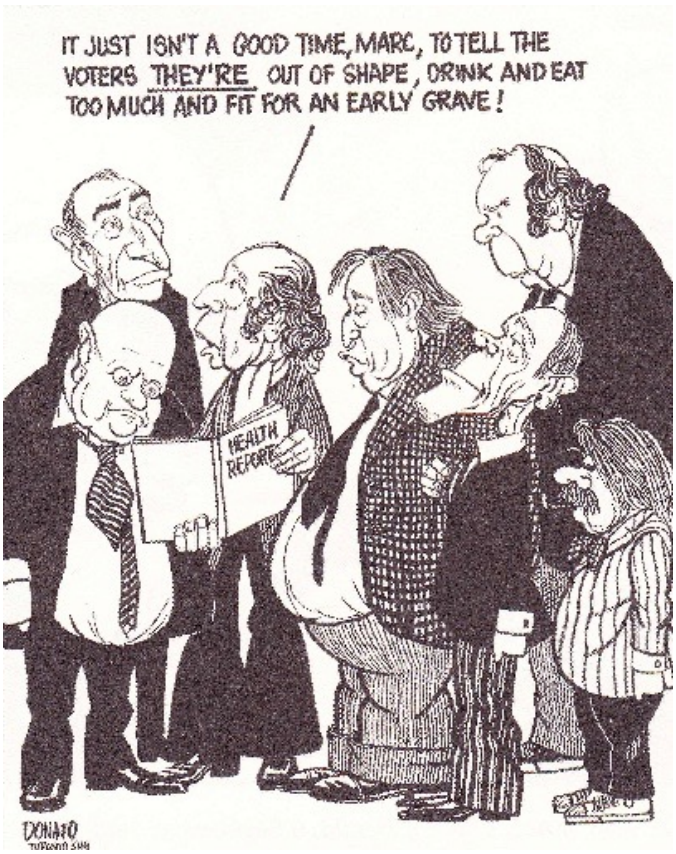

Figure 3.2 Negotiating the boundaries of liberal governance: "not a good time"? (Source: Library and Archives Canada, Acc. No. 1993-169-348 © Andy Donato. Reproduced with permission).[7]

3. After Lalonde: The New Public Health and the Emergence of the Healthy Cities Movement

The Lalonde report was a key document in the precipitation of a loosely interrelated set of initiatives of varying degrees of success and influence. One thing they had in common was that they trained attention on cities and local environments as places where health promotion and the new "holistic" approach to governance envisioned in the discourse of "healthy public policy" could be operationalized. Thus, by the mid-1980s the core argument of the Lalonde Report was receiving increased attention and elaboration at

[7] Originally printed by the *Toronto Sun* May 3rd, 1974. Also reproduced in Pope, 2012: "Political Cartoonists Respond to Medicare," in *Making Medicare: New Perspectives on the History of Medicare in Canada.* Gregory Marchildon, ed. p. 105.

official institutions of power at the municipal, federal, and international levels. Key events in the late 1970s and 1980s that were crucial to the development of the health promotion idea and to its institutionalization and legitimization in the Canadian public policy context included the 1978 Alma Ata Declaration, a 1984 conference in Toronto on "Healthy Public Policy", and, in 1986, the publication of the Ottawa Charter on Health Promotion (WHO, 1986), and *Achieving Health For All* (Epp, 1986) by Health and Welfare Canada (see Table 3.1 below). Through these forums and the policy statements they produced, the health promotion concept was developed and dispersed. In the process, it also underwent some conceptual changes.

Table 3.1 Key Events in the Genesis of "Healthy Cities"

Date	**Event**	**Location**
1974	Lalonde Report published	Ottawa
1978	Alma Ata Declaration	Alma Ata, Kazakhstan/USSR
1984	Health Beyond Health Care conference	Toronto
1986	Ottawa Declaration	Ottawa
1986	WHO Europe Healthy Cities Project launched	Lisbon

Perhaps most significantly, the New Public Health's spatial imaginary began to be more clearly defined. Whereas the Lalonde Report had, in somewhat vague terms, identified urban space as a problem area, in later iterations of health promotion the city came to occupy centre stage as the spatial vehicle through which "healthy public policy" could be operationalized. Thus, whereas Lalonde highlighted urban space, "modern living," and the "darker side of progress" as problem sites for the development of a new approach to the

health of Canadians, the Healthy Cities movement took on cities and urban space as a key site for policy and program development and experimentation. Drawing on the idea of a whole of government approach, a new discourse of "healthy public policy" emerged as means of operationalizing health promotion across the urban milieu. It is for this reason that those who took up Lalonde's core argument looked back towards the accomplishments of public health in the 19th and early 20th centuries in an effort to advance an agenda for a New Public Health. It became crucial to rehabilitate and remember the forgotten truth that "the greatest contribution to the health of the nation over the past 150 years was made, not by doctors and hospitals, but by local government" (op cit., p. 108). In this way the New Public Health was actively engaged in bringing this past into the present, as a kind of lost or forgotten golden age, and as a "natural" extension of the "cities and towns movement" of the mid-19th century. As former Toronto-based public health activist and scholar Trevor Hancock once romantically reflected:

> **Hygeia, a city of Health, 1875**. The vision of an ideally healthy city sketched by Benjamin Ward Richardson, a self proclaimed disciple of [Edmund] Chadwick, and his biographer, has been an inspiration to me since I first came across it some twenty years ago. It certainly helped to stimulate and crystalize my own thinking about how to make a city healthy, and it is now the name of one of my business partnerships, which focuses on how to design healthy communities. (Hancock, 1997, p. 12)[8]

The city of Toronto was a key space through which the related discourses of healthy public policy and healthy cities gained broader currency and, ultimately, international mobility.

[8] Hancock worked for Toronto Public Health from 1980-1988, during which time he served as associate Medical Officer of Health for the North Toronto Health district. He now lives in Victoria, BC.

3.1 "Public Health in the 1980s": The Emergence of the New Public Health in Toronto

Spurred by the publication of the Lalonde Report, the Toronto Board of Health passed a motion in January 1976 to initiate a study of the status quo of public health in Toronto. A Health Planning Steering Committee was appointed and tasked with three major objectives: first, to evaluate then-existing programs and the organization of the Department of Public Health in terms of "current and future 'public' health needs of the city of Toronto"; second, to undertake "considerable consultation with the Department staff and community at large, develop positions and recommendations on future roles and programs of the Department of Public Health and the Board of Health of the City of Toronto"; and third, to incorporate a "continued planning and evaluation component into the Department" (Toronto Health Planning Steering Committee, 1978, p. 28).

A major impetus for this reexamination of public health was the perception articulated in the Lalonde Report that the context, role, and philosophy of public health were in the midst of a "sea-change." In its brief discussion of the history of public health the report noted that public health as a discipline dates to the 19th century and, therefore, "was created and developed to deal with the chief threat of [that] century: *infectious disease*" (Toronto Health Planning Steering Committee, 1978, p. 34, emphasis in original). They further argued that both public health practice and public health legislation needed to undergo significant change to be brought into the 20th century:

> The public health act of Ontario was enacted in 1884 to deal with sanitation problems and outbreaks of infectious disease in what was then an essentially rural province. Though the *Act* has been patched and amended almost annually since, the alterations reflect insufficient change in the underlying assumptions regarding public health's mandate. We must ensure that the thrust of the proposed *Provincial Health Protection Act*[9] – soon to replace the *Public Health Act* – embodies a set of assumptions which reflect the real needs of the 1980's: not the 1880's. (pp. 35-36.

[9] Adopted in 1984 under the revised title of the *Ontario Health Protection and Promotion Act.*

In identifying the "new mandate" required by/for public health, the Report echoed Lalonde in some respects, for example in the growing importance of "non-communicable diseases (heart disease, cancer, cerebrovascular disease and accidents)," which are the "leading cause of death in Toronto, accounting for nearly 70 percent of all deaths" (Toronto Health Planning Steering Committee, 1978, p. 36). However, the Report was also careful to outline a key point of divergence from Lalonde: his perceived emphasis on "lifestyle" issues. Arguing that social factors constrain "choice," they stated that the "so-called diseases of choice" were in fact social products, and therefore, that in the public health of the future there ought to be a strong emphasis on regulating the industries that profit from producing and promoting "unhealthful" lifestyle choices and environments: "There has been insufficient emphasis" on "contributory factors which influence the behaviour of individuals, such as heavy advertising for tobacco and alcohol; or on those factors over which individuals, in fact, have no control, such as food processing and the environment" (p. 43). While reasserting the continued importance of public health's more traditional role in "educating the individual" they asserted that, in addition, there must also be "broader" educational efforts directed a helping "society" to "recognize the economic and social damage it suffers in having to deal with diseases of improved lifestyle, and the necessity of removing pressures which force individuals into unhealthy patterns of living" (p. 43).

The Report therefore staked out bold regulatory positions on issues such as food processing and the availability of "unhealthful" food and its advertising, and suggested outright bans on both advertising and the sale of "junk-food," including the banning of "all additives and unnecessary processing of staple foods. With advances in refrigeration and transportation, additives are no longer necessary to avoid spoilage" (Toronto Health

Planning Steering Committee, 1978, p. 10). It further recommended that the Department of Public Health work towards the "prohibition of all commercial food advertising, on the grounds that no one requires the urging of a commercial advertisement to eat." And, as a more "immediately achievable goal," the *Public Health in the 1980s* report argued that "the Department should seek to establish the requirement that food advertising be limited to those products of significant nutritional value" (p. 10). It was also recommended that the department develop a research program aimed at understanding "the most effective means of assuring adequate nutrition for low-income and immigrant families, the elderly, and school children, and develop programs to meet the needs of these groups" (p. 11). Perhaps most tellingly, the report made the following observations about the availability of nutritious food in Toronto:

> While outright lack of food is rare in Toronto, the displacement of wholesome food by less wholesome, virtually worthless, or possibly harmful food, is rampant…. What is not very well recognized is the degradation of formerly nutritious food (such as bread, hotdogs and peanut butter) by additional refining which may remove nutrients; or by alteration of food so that nutrients are less readily available; or perhaps by substitution of cheaper and less nutritious ingredients. (p. 44)

Thus, to a large extent, *Public Health in the 1980s* responded to the Lalonde Report by imagining a strong role for Toronto Public Health in protecting relatively powerless and unsuspecting citizens from the influence of more powerful corporations that stood to profit from the marketing of unhealthy "choices." In this way it did not share Lalonde's level of concern with "passive" citizenship. And, while questions of poverty and material deprivation were clearly on the radar, they were perceived as minor relative to the larger threat of corporate deception and persuasion.

3.2 Healthy Cities

The Healthy Cities and Communities movement emerged out of a 1984 conference entitled "Beyond Health Care" (Hancock, 1997). It was hosted by the Toronto Department of Public Health in honour of Toronto Public Health's centenary. According to public health scholar and healthy cities activist, Trevor Hancock, who was employed by the Toronto Department of Public Health from 1980-1988, the genesis of the World Health Organization (WHO) Healthy Cities project can be traced to this conference. More specifically, Hancock traces it to a workshop associated with the conference, with the millennial- and future-oriented title "Healthy Toronto 2000." It was at this 1984 workshop that founder and long-time director of the WHO Healthy Cities program, Dr. Illona Kickbusch, got the idea. As Hancock explains:

> Her interest in the concept of healthy cities had been sparked by a one-day workshop–Healthy Toronto 2000–organized in conjunction with a 1984 conference on healthy pubic policy…. She saw in the healthy city concept the potential to take the concept of health promotion then under development at WHO Europe off the shelf and onto the streets of the cities of Europe, to take global concepts and apply them locally and concretely. (1997, p. 16)

Speakers at the 1984 workshop included Mayor Art Eggleton, Ward 11 Alderman and Board of Health member Anne Johnson; and Leonard Duhl, professor of public health at University of California Berkley campus. According to Hancock (1997), Duhl's speech, entitled "The Healthy City: Its Function and its Future," was noted as being particularly inspiring (Duhl, 1984, 1986).[10]

Following this conference the WHO, under the leadership of Kickbusch, organized a Healthy Cities Project for Europe. Commencing in 1986, it initially included

[10] The proceedings of the Beyond Health Care Conference, including many of the Healthy Toronto 2000 presentations, were subsequently published in a special 1985 issue of the *Canadian Journal of Public Health*; a version of Duhl's paper was published in the inaugural issue of the *International Journal of Public Health*, edited by Kickbusch, in 1986. Interestingly, this is the only paper to emerge from that workshop which was *not* subsequently published in the 1985 Special Issue of the *Canadian Journal of Public Health*.

11 cities, but grew to include 35 by 1991(Hancock, 1997). The program is still active today with a presence of some 100 cities in 30 European countries (WHO, 2015).[11] In Europe, healthy cities initiatives centre around the collection and organization of data for 32 different indicators thought to be connected to a broad range of heath determinants (Webster & Sanderson, 2012).[12] The idea is to produce data that are comparable across space and time to allow cities and their policy makers and citizens to track and compare with other jurisdictions their progress on specific health-related goals (Webster & Sanderson, 2012).

3.3 The Epp Report: Health for All

In 1986 Brain Mulroney's Minister of National Health and Welfare, Jake Epp, released *Achieving Health for All*. This policy statement marked another key moment in the genealogy of the health promotion and healthy cities ideals. The Report reiterated and expanded upon the health promotion principles articulated by Lalonde. The document was released in the context of an international conference on the subject of health promotion held in Ottawa and sponsored by the Department of National Health and Welfare and the World Health Organization. The conference resulted in the signing of the *Ottawa Charter on Health Promotion*, an international consensus prioritizing the principles of health promotion. This consensus reintroduced the WHOs 1946 founding definition of health as a "state of complete mental, physical and social wellbeing" and stressed the need for goal setting based on the collection of comparable historical and cross-national data.

Subsequently, *Health for All* document (Epp Report) was widely distributed to "community groups, provincial governments and professionals across the country"

[11] See http://www.euro.who.int/en/health-topics/environment-and-health/urban-health/activities/healthy-cities/who-european-healthy-cities-network (accessed November 15, 2015).
[12] This number was the result of a downward revision from 53 indicators in 1998 (see Webster & Sanderson, 2012, p. S54).

(Chrichton, 1997; McKillop Farlow, 1987, p. 9). The Epp Report reiterated the health promotion message of Lalonde, but placed emphasis on the necessity to address health inequalities. In particular, the report highlighted income inequality, gender, and Aboriginal status as key axes of inequities; it also elaborated on aspects of contemporary society that made these categories salient for health inequality.

The *Health for All* document re-iterated Lalonde's argument that a new vision of health was necessary in the face of the changing nature of disease. Shifting priorities in health were framed and articulated as the logical outcome of objective historical forces associated with "progress," rather than, for instance, a reaction to crisis tendencies in capitalism or political decisions about spending priorities: "In the past, when infectious disease was the predominant cause of illness and death, health was defined in terms of the absence of disease. By the mid 1900s however… health had come to mean more than simply not being ill" (Epp, 1986). Echoing Lalonde's concern with "the dark side of progress," the Epp Report added an explicitly classed and gendered set of concerns: "The times in which we live are characterized by rapid and irreversible social change. Shifting family structures, an ageing population and wider participation of women in the workforce are all exacerbating certain health problems and creating pressure for new kinds of support" (Epp, 1986). In other words, as middle-class women increasingly entered the paid labour force, this raised new challenges. Certain kinds of domestic labour and domestic spaces could no longer be taken for granted as places where health and care work "beyond health care" were attended to.

The report referenced the Lalonde Report and its emphasis on "a broad range of factors: human biology, lifestyle, the organization of health care and the social and physical environments in which people live." This line of analysis had "legitimized the idea

of developing health policies and practices within a broader context" (Epp, 1986). *Health for All* refined the discourse of health promotion in the several key ways. First, it distinguished between "social" and "physical" environments, as well as between "environment" and "where people live." In the Lalonde Report, neither of these precise delineations or locations of "environment" had been stated. Second, in the Epp Report, questions of social inequality were brought into sharper focus relative to the health promotion agenda in Canada. In particular, as noted above, forms of inequality along the lines of socio-economic inequality, gender, age, and Aboriginal status were brought into increased visibility at that time.[13]

Health for All was also concerned with the notion of "resources." Previous discourses, such as that of the Hall Report, articulated public investment in health as a national and collective investment in human resources through the language of "human capital." In the Epp Report health itself became a "resource for everyday living," a resource to be more or less directly accessed by "individuals and communities." Health was imagined as a resource that enables people to be in control of their lives and destinies, and the development of active citizenship, the latter of which makes it possible for people and communities to change or improve their own circumstances. As the report stated, "[h]ealth is thus envisaged as a resource which gives people the ability to manage and even change their surroundings. This view of health recognizes freedom of choice and emphasizes the role of individuals and communities in defining what health means to

[13] The slogan of "Achieving Health for All" appeared in 1977 at the WHO's World Health Assembly in Geneva, Switzerland, as part of an emphasis on global access to primary care. In this context it was argued that health promotion could be a key strategy in achieving a global baseline minimum level of health for all people by the year 2000. Significantly, that minimum was defined as "a level of health that would permit them to lead a socially and economically productive life. In other words, at a minimum, all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live" (WHO, 1998: http://www.who.int/whr/1998/media_centre/executive_summary6/en/ Accessed November 5, 2015).

them" (Epp, 1986). In this way, health as resource begins to be seen in terms of the dynamics of localized "social, physical and cultural environments."

In this context, techniques for knowing and producing knowledge about health were reevaluated and modified. Previously, and up to and including the Lalonde Report, the centrality of mortality and morbidity were not questioned, though limitations were sometimes pointed out. *Health for All* had a more radical and explicit gesture towards knowing health differently. Specifically, rather than the expansion of health knowledge being linked exclusively to objective forces of scientific advancement, health was defined as having subjective dimensions, as something that could be both assessed and attainted through the actions of individuals and communities. As the report stated:

> Viewed from this perspective, health ceases to be measurable strictly in terms of illness and death. It becomes a state which individuals and communities alike strive to achieve, maintain, or regain, and not something that comes about merely as a result of treating and curing illnesses and injuries. It is a basic and dynamic force in our daily lives, influenced by our circumstances, our beliefs, our culture and our social, economic and physical environments. (Epp, 1986)

Health for All called far more attention to income inequality than was the case in the Lalonde Report: "There is disturbing evidence that despite Canada's superior health services system, people's health remains directly related to their economic status" (Epp, 1986). The report concluded: "our system of health care as it presently exists does not adequately deal with the major health concerns of our time" (Epp, 1986). Thus, one of the major challenges identified was to reduce "inequalities in the health of low-versus high-income groups in Canada" (Epp, 1986). However, there was no mention of poverty or its elimination. Health inequality was represented in terms of differential mortality and morbidity rates in high- and low-income groups. "Among low-income groups" it stated, "people are more likely to die as a result of accidental falls, chronic respiratory disease, pneumonia, tuberculosis and cirrhosis of the liver." Further, "certain conditions are more

prevalent among Canadians in low-income groups; they include mental health disorders, high blood pressure and disorders of the joints and limbs" (Epp, 1986). This was further parsed into specific sub-populations:

> Within the low-income bracket certain groups have a higher chance of experiencing poor health than others. Older people, the unemployed, welfare recipients, single women supporting children and minorities such as natives and immigrants all fall into this category. More than one million children in Canada are poor. Poverty affects over half of single-parent families, the overwhelming majority of them headed by women. These are the groups for whom "longer life but worsening health" is a stark reality. (Epp, 1986)

The Epp Report's framework for health promotion consisted of three main "mechanisms and strategies" to make health promotion another "equally important cornerstone" of the Canadian health system alongside Medicare (Epp, 1986). First, self-care, or the "decisions and practices adopted by an individual specifically for the preservation of his or her health." Examples included "An older person using a cane when the sidewalks are icy, a diabetic self-injecting insulin, a person choosing a balanced diet, someone doing regular exercises". Second, mutual aid, or collective actions taken by groups to "help each other cope." The third was "the creation of a healthy environment," which entailed

> altering or adapting our social, economic or physical surroundings in ways that will help not only to preserve but also to enhance our health. It means ensuring that policies and practices are in place to provide Canadians with a healthy environment at home, school, work or wherever else they may be. It means communities and regions working together to create environments which are conducive to health." In this sense the environment is understood as "all encompassing; the concept of boundaries is inappropriate when we speak of the promotion of health. (Epp, 1986)

For these reasons "environment" was identified as the most complex and challenging of the "three mechanisms or kinds of action required for the promotion of health."

Table 3.2: Health Promotion Framework: Strategies and Mechanisms[14]

Mechanism	Self-Care	Mutual Aid	Creating Healthy Environments
Strategy	Fostering Public Participation	Strengthening Community Health Services	Coordinating Healthy Public Policy

The Epp Report also contrasted the New Public Health with the "traditional" view of health promotion as synonymous with the dissemination of health information. The report characterized this view as outdated and naïve, since it presumes that information will lead directly to changes in behaviour and lifestyle choices by the general public. More recent health promotion thinking, it was argued, is more sophisticated in that it recognizes that to be effective, information campaigns cannot take place "in isolation." Such campaigns needed to be accompanied by a variety of other activities such as "education, training, research, legislation, policy coordination, and community development" (Epp, 1986). By the mid-1970s, due to a widening acceptance of this realization among "many professionals and the voluntary community" health promotion activities "were becoming more visible in schools, community health services, drug and alcohol commissions and in the workplace" (Epp, 1986).

An emerging notion of healthy public policy was being conceptually and discursively tied to the need to produce "healthy environments." "Environments" and "policy" were rearticulated as borderless and as calling for a kind of "holistic" approach. Health challenges were national in scope but demanded localized and identity-group-specific solutions and responses. "[F]or public policies to be healthy," it was stated "they must respond to the health needs of people and their communities. This is so whether

[14] Adapted from Epp, 1986.

they are developed in government offices, legislatures, board rooms, church halls, union meetings or centers for seniors". The Report expanded the definition of health: "All policies which have a direct bearing on health need to be coordinated. The list is long and includes, among others, income security, employment, education, housing, business, agriculture, transportation, justice and technology". Noting that health was "not necessarily a priority for other sectors," the report stated "we have to make health matters attractive to other sectors in much the same way that we try to make healthy choices attractive to people" and try to promote "a vision of health as a dimension of the quality of life" (Epp, 1986).

3.4 "Healthy Toronto 2000"

Pursuant to the "Beyond Health Care" conference and associated workshop discussed above (pp. 131-132), the Toronto City Council appointed a municipal subcommittee with the millennial and goal setting name Healthy Toronto 2000. Chaired by then-counselor Jack Layton, the subcommittee had a mandate "to determine what will be the major health challenges faced by the City of Toronto during the 1990's" (City of Toronto, Board of Health 1988, p. 113), and to provide the city with a "Healthy City Strategy." The subcommittee was tasked with three main objectives:

> provide policy guidance to the Department [of Public Health] for the next decade…provide leadership to the City administration in the development of a coordinated plan for Healthy Toronto 2000…[and] prepare reasonable and data based arguments for making health a priority on the political agendas of the City, provincial and federal governments. (p. 113)

In 1988, the subcommittee published its report and recommendations under the same name – "Healthy Toronto 2000".

Part of the committee mandate was also to evaluate the implementation of the earlier report, published in 1978 and entitled *Public Health in the 1980s* (1988, p. i). "Healthy

Toronto 2000" was thus the second report that the city produced in response to the challenges and opportunities posed by health promotion. However, the shift in authorship is notable, in that with it, "heath" moved from the comparatively "narrow" responsibility of the Department of Public Health to that of the city at large. The Healthy Toronto 2000 subcommittee noted that they were satisfied with the implementation of the previous, 1978 report, which responded initially to the emergence of the ideas of the "New Public Health," and which they referred to as a "paradigm shift". "Ten years ago," it was stated, "the role, function and structure of the Department of Public Health was radically altered by the report, 'Public Health in the 1980s.'" Pursuant to those changes the Department became "far more active in a wider range of public health issues." This had led to a "new realization – that much that will promote or enhance the health of the people of Toronto lies 'beyond health care' – as the Board of Health's centennial conference put it in 1984 – and beyond public health itself" in the direction of "healthy public policy" city-wide (1988, p. 1).

The impetus for a renewed look at the relationship between health and public policy at the municipal level in the mid 1980s was nevertheless still framed in terms of the "sea change" in health thinking triggered by the Lalonde Report:

> In 1974 the federal government published *A New Perspective on the Health of Canadians*…. This report had a dramatic effect on our approach to and understanding of health, internationally, nationally and locally. The report showed that a health care system was only one determinant of the health of Canadians, and that future improvements in health would result primarily from changing environments and lifestyles. (1988, p. 34)

In short, the Healthy Toronto 2000 report was characterized as an "evolution and refinement in our thinking" since the 1970s (1988, p. 34). In particular, Healthy Toronto 2000 equated this progress with the emergence of a citywide prioritization of health, in the

spirit of development towards the whole of government-style approach envisioned by Lalonde. The proposed Healthy City Strategy stated it

> recognizes that the process of improving the health of the community is slow and complex; that the profound changes in social values and attitudes that are necessary are the result of long-term commitment to a multi-faceted and broad-based process of social change; and that many of the challenges to health that we face are interrelated and will require a holistic approach for their resolution. (1988, p. 1)

In order to achieve these ideals the Healthy Toronto 2000 subcommittee came up with 89 recommendations in 10 broad categories, which it believed would "make Toronto the healthiest city possible" (1988, p. i). In this way, it adopted the "healthy public policy" paradigm mobilized through the WHO and the "Beyond Health Care" conference. This thus distinguished between the "health goals of the city" and those of the Department of Public Health:

> A recognition of the breadth of our concerns with health, compared with the somewhat narrower responsibility of the Department of Public Health, leads us to an inevitable conclusion. City government as a whole and the community-at-large of the City must become involved in any effort to make Toronto the healthiest city possible. This calls for a broad, multi-sectorial and community based initiative which the board of health and the department of public health can help to initiate but can not implement alone (1988, p. 2)

Here, all of the city's residents and communities were called upon to become involved in the project of producing the healthy city, and to realize the Department's mission: "make Toronto the healthiest City in North America" (1988, p. 34).

The *Healthy Toronto 2000* Report (1988) recommended a "healthy city initiative" that would include a healthy city office, a healthy public policy committee, separate but related health goals for the City and the Department of Public Health, a health promotion strategy, and the delineation of "Three Priority Concerns." The citywide goals were fourfold: (1) "reduce inequities in health opportunities in Toronto", (2) "create physical environments supportive of health", (3) "create social environments supporting of health"

and (4) to "advocate for a community-based health services system" (p. 2). The public health Department had five specific goals, including (1) the creation of "healthful environments", (2) the protection of residents from health hazards, (3) the collection of health data for the purpose of health planning, (4) promoting the Healthy City Initiative "in all aspects of City life and government," and (5) enabling "the people of Toronto to develop health promotion skills and achieve their health potential" (p. 2). The report's health promotion strategy self-consciously reflected the strategies of the Ottawa Charter and emphasized the themes of individual and community empowerment. It emphasized the creation of policies and environments supportive of health and the development of "personal skills for health" and enabling "the people of Toronto to develop health promotion skills and achieve their health potential" (p. 3).

Similarly, the Three Priority Concerns were first, "to work with those with the greatest inequalities in health", second, to recognize diversity and develop "culturally appropriate" efforts directed at "those communities with the greatest inequalities" and third to "re-orient health services towards health promotion and a community based health system" (p. 3). Furthermore, the report stated "social interventions to enhance the common health of the community [would be] appropriate and may take precedence over individual concerns" (p. 1).

Another shift was the change from a regulatory or prohibitionary approach, directed in large part at profit-seeking corporations, toward an "empowerment approach," directed at "individuals, neighbourhoods and communities." The two reports' discussions of the relationship between food and health were particularly instructive. The *Healthy Toronto 2000* Report (1988) observed that the number of food banks in Toronto had risen dramatically between 1981 and 1988 (p. 50). It recommended the establishment of a food

policy council to ensure that Torontonians had enough safe nutritious food to eat to ensure that "there will be no hungry people in Toronto" and that there would therefore be "no need for food banks in Toronto" (1988, p. 10). In terms of concrete recommendations, however, most of these were geared towards traditional public health goals such as sanitation and hygiene inspection and nutrition education.

Comparatively speaking, the *Public Health in the 1980s* report, published in 1978 (discussed above at pp. 128-130), took a much bolder position. The latter report suggested that the city could and should take strong regulatory positions toward the food (as well as tobacco and alcohol) industries profiting from the advertisement and sale of unhealthful foods (Toronto Health Planning Steering Committee, 1978, pp. 35-36). This may be explained by the sense of optimism about the publication of the Lalonde Report and the rewriting of Ontario's public health legislation, which was underway in the late 1970s. By the time of 1988 report, this had shifted once again to an emphasis on inspection and education, accompanied by assertions that there ought not to be food banks. This shift might be a reflection of the fact that, as Chrichton et al. (1997) argue, structural and legal change did not necessarily follow from the popularity of the *idea* of health promotion (see also Labonté, 1994).

While Healthy Cities continued to be an active WHO-sponsored program in Europe, in Canada its influence has been more uneven, more dispersed across private forms of initiative, and less focused on the measurement of outcomes (Taylor, 2010). Nevertheless, interest in the concept appears to have been reinvigorated in the post-2008 period. In 2010 the Canadian Institute of Planners (CIP) produced a document to guide planning in the name of healthy communities: "The CIP Healthy Communities Practice Guide was created to help planners discover opportunities and methods for collaborating

with health professionals as well as various other professionals, stakeholders and community members towards a common goal for healthy communities" (Canadian Institute of Planners, 2010, p. 1). Produced with support from Health Canada, the Heart and Stroke Foundation, and the Canadian Partnership Against Cancer, the document highlighted "diseases associated with obesity and low rates of physical activity – heart disease, stroke, high blood pressure, type two diabetes" (2010, p. 1). These were seen as key problems around which planners and health professionals could learn to collaborate more effectively. Accordingly, there was significant emphasis on promoting walking and cycling in land use and transportation decisions, as well as the presence of green space and healthy food options. The holistic picture of an ideally healthy city was presented in the following visioning exercise:

> If you ask someone to envision their ideal healthy community, they might describe a scenario similar to the following. Birds chirp overhead, perched in the limbs of a tree. You take a moment to stop and enjoy your surroundings, feeling calm and connected: native plants and perennial herbs that line the boulevards; the last of the previous day's rain percolates back into the earth through the bioswale beside the path. You are on your way to work, and during the 10 minute walk between your home and office you encounter several neighbours at the local coffee shop. They are trading stories about meals made with the delicious vegetables they picked up at the farmers market on the weekend. At your office you meet a co-worker as he locks-up his bicycle in the buildings bike parking and once settled at the desk you open the window and let in the mornings cool, natural air. (2010, p. 1).

Under the leadership of then Medical Officer of Health, David McKeown, Toronto Public Health (TPH) rehabilitated the "healthy cities" concept as a means to help the city face the challenges of a post-2008 economy. Toronto Public Health's 2011 report, *Healthy Toronto by Design*, offered the idea of healthy cities a means through which Toronto could face the challenges of the 21st century global political economy while simultaneously meeting the "health needs and challenges of all residents" (Toronto Public Health, 2011, p. ii). The healthy cities concept encouraged collaboration between city departments and

the public to "develop and implement holistic responses to the challenges a city faces" (p. iv). There was emphasis on economic prosperity and the role of holistic public policy in shaping the built and social environments. The report stated, "[h]ealthy Cities are cities that are prosperous, livable and sustainable" and the healthy cities approach "challenges local governments to be aware of health issues embedded in all policies, programs and services" (p. iv). For this reason, while the Department of Public Health would have an important leadership role to play, the production of the healthy city was by no means the task of a single department or bureaucracy. Rather, "all parts of municipal government, business and the community play a vital role in enabling and supporting positive health outcomes for everyone" (p. iv).

These goals were also framed in terms of the political and economic objective of making Toronto a globally competitive city in a context in which desired workers and employers are presumed to be highly mobile. For example, it explained "[f]actors that make a city healthy also make a city livable for residents and good for business – cities where people like to live are cities that provide business with more customers and potential employees" (Toronto Public Health, 2011, p. 2). As the Report further stated, "[h]ealth contributes to the prosperity of the city because to drive innovation and economic growth, businesses depend on a productive work force – well educated and healthy men and women" (2011, p. 22). The report remarked that while Toronto had historically fared well in competitive city rankings of "livability," the city had been losing ground to other cities in recent years.

> There are many different quality-of-living surveys. Toronto often ranks among the best cities. However, maintaining these top rankings requires the city to continually invest in remaining an attractive place to live and do business in. The Toronto Board of Trade Scorecard on Prosperity compares 25 global cities. In 2011 Toronto ranked 8th, down from 4th in 2010 and 2009. (2011, p. 3)

Key areas in which Toronto does poorly are "productivity and innovation" and the longest commute times of all 25 cities included in the ranking. The Report also notes, almost in passing, that the same Toronto Board of Trade scorecard flagged "Toronto's Gini co-efficient (a measure of equality)" as "the lowest among Canadian metropolitan areas" (2011, p. 4). While housing, food security, and low income were all flagged as detrimental to health, and goals such as eradicating hunger are also flagged, there was no mention of the experience of poverty and material deprivation as an indication of suffering, or as an affront to ideals of democracy, social justice, and so forth. Instead, poverty appeared as a problem of spatial concentration, which is particularly significant in light of the emergent emphasis on the spatial communities of neighbourhoods in shaping people's health.

> In cities such as Toronto, studies have found an increasing concentration of poverty in certain neighbourhoods…. The concentration of poverty in these neighbourhoods makes it increasingly difficult for individuals to escape poverty, threatens social and community cohesion and can lead to a cycle of neighbourhood deterioration and disinvestment. (p. 16)

As the report insisted, "where we live matters to our health." This is because the "social and economic features of neighbourhoods have been linked with mortality, self rated health, disability, birth outcomes, chronic conditions and their risk factors, mental health, injuries, and violence" (p. 14). Thus, low-income neighbourhoods were described as "high risk environments." By contrast, healthy, health-promoting environments understood as akin to those envisioned above by the Canadian Institute of Planners: green, walkable, and with high levels of "social capital."

4. Conclusions

This chapter has discussed the new urban spatial imaginary that emerged in the wake of the Lalonde Report's attempt to shift the discourse in health policy away from curative medicine and the expensive funding of doctors and hospitals and towards the promotion of health "beyond health care." Within this imaginary, cities were foregrounded as having a particular significance, both for the identification of environmental and lifestyle-related risks to health, and as sites through which the New Public Health could be operationalized. The new urban spatial problematization of health that this represented therefore brought with it an imperative to generate new kinds of knowledge about cities and the kinds of health risks and opportunities that are understood as uniquely tied to them.

The chapter documented the changes that are discernable in the articulation of the objects of health promotion-oriented public policy, the re-articulation of its main strategies and goals, and the shifts in how this knowledge about life and health have been represented in the last quarter of the 20th century. It argued that we can observe three interconnected transformations. First, because health promotion strives to be a science of prevention, it is necessarily future-oriented. Thus, its problem space entails the production and dissemination of as-precise-as-possible knowledge about risks in order to ask citizens and communities to modify their behaviours. The distinction Lalonde made between morbidity and mortality and their underlying causes was central. Second, and related to the specifics of this future-oriented perspective, the health policy vocabulary came to increasingly rely on concepts such as "wellbeing," "promotion," "dis-ease," and "holism," all of which were tied to its risk-averse and behaviour modification emphases. Third, the city came to be depicted as the natural scale for the whole of government approach. This

was partly due to the presumption that cities were disproportionately "risky" to health, and partly in response to political and economic perspectives which view cities, and "World cities" in particular, as the central nodes and drivers of wealth production and accumulation. Thus, beginning in the 1980s, "health promotion" became operationalized, at the scales of city, neighbourhood, and community. This had the effect of responsibilizing individuals, communities, and neighbourhoods for the production of optimal health outcomes, defined first and foremost in the exchange-value terms of being a member of the capitalist workforce.

This privileging of the neighbourhood and the community had the effect of localizing the formulation of both problems and solutions to concerns in the field of "health." Risks stemmed first and foremost from *localized* forms of insecurity. This would have important consequences for the trajectory of the development of risk-profiling epistemologies and techniques, as new techniques for representing the spaces of health become increasingly involved in the visual and discursive representation of "risks" in the late 20th and early 21st centuries.

Finally, the future orientation of risk notwithstanding, the discourses of health promotion and healthy cities were also decidedly backwards looking in their understanding of progress. The *Healthy Toronto 2000* Report (1988) cited above (op cit. p. 130) reiterated the story of Edmund Chadwick and the birth of the healthy cities and towns movement in 1840s England as an origin story, in much the same way as the 1980s activists who had just "rediscovered" it did (see also Ashton 2009; Hancock 1988; Hancock 1997; Toronto Public Health, 2011). This form of nostalgia and its role in claiming legitimacy for the New Public Health stands in marked contrast to that of

population health and its approach to understanding how local and social space determine health.

If health insurance is a *form* of insurance technology (Ewald, 1991, emphasis added) aimed at the socialization of risk across a given population, then it follows that Lalonde's rearticulation of risk as an entity to be managed largely outside of the formal health care system was first and foremost an individualization of risk. However, at the same time, the health promotion concept and its mobilization through the idea of healthy cities did not abandon what François Ewald called the *insurantial imaginary* (1991, p. 198, emphasis in original). For Ewald, a given institutional expression or form of insurance is but one aspect of the overall insurance phenomenon. What unites wildly different forms of insurance and their corresponding institutions (i.e. health insurance, auto insurance, life insurance, old -age pensions, and so forth) is their existence as techniques for the social management of populations in industrial societies (Defert, 1991). At its most basic, insurance is a technology of risk that functions as an "art of combinations". In this, risk is nothing but "a neologism of insurance" (Ewald, 1991, p. 198). Thus, as Ewald explains

> Insurance institutions are not repetitions of a single formula applied to different objects: marine insurance is different from terrestrial insurance; social insurance institutions are not just nationalized insurance companies. Insurance institutions are not *the* application of a technology of risk; they are always just *one* of its possible applications. This indeed is something that the term 'combination' helps to make clear: insurance institutions never actualize more than one among various possible combinations. (pp. 197-98)

Insurance is a quintessentially biopolitical technique, that ties individuals to collectivities in different ways. Seen in this light, the advent of health promotion is not only individualizing, but also rearticulates the subjects and objects of risk into distinct collectivities. The city moves from being the spatial expression of "risk" to the national body, and to a space of community as a group of risk sharers. The urban and its

constitutive populations become the subject and object of risk management techniques, i.e. the subjects and objects of a shifting insurantial imaginary.

Chapter 4
The Vital Politics of Space: Wellbeing, Risk, and the Local Environment as Determinants of Health

> In a city with so many great pockets, and many more improving faster than you can say gentrification, the competition for the title of Number One Neighbourhood is cutthroat. To end the uncertainty, we present the ultimate ranking of the city's 140 neighbourhoods. We examined 10 factors for each, assigning them a score out of 100: housing, crime, transit, shopping, health and environment, entertainment, community engagement, diversity, schools and employment.
>
> — Andrew D'Cruz et al., *Toronto Life*, Real Estate, 2013

> Researchers used 11 databases, extracting information and then geo-coding it, for example, based on postal code, to reveal precise details on neighbourhoods. Most of the information has never before been available drilled down to such a local level…. Released online Wednesday evening the 'Urban HEART @ Toronto' tool gives each neighbourhood a rating of red, yellow or green for each of the 15 indicators.
>
> –-Theresa Boyle, *Toronto Star,* 2014

> A sign of the times we live in is that while there are lots of quarrels about what indicators one should use when ranking cities, nobody is questioning the idea of competitive city rankings.
>
> — Marianna Valverde, *Everyday Law on the Street*, 2012

1. Introduction

By the dawn of the new millennium health status had become an integral classification in techniques of neighbourhood mapping, ranking, and benchmarking in the city of Toronto. Neighbourhood-level rankings and benchmarks were being produced by a range of actors and for various purposes. However, by and large these rankings are informed by "a social determinants of health model" (Doolittle, 2014) and the desire to "get a holistic view" of neighbourhood wellbeing, in order to "focus on the strengths and the risks" (O'Campo, cited in Boyle, 2014).

What this amounts to is a new way of seeing life in urban spatial terms, which takes the emergence of the science of epigenetics and the growing application of GIS/GIScience

capabilities to the social field as key conditions of possibility. In Canada the science of epigenetics entered the health policy field through the influence of the population health paradigm. Importantly, it allowed for a new conceptualization of the relationship between health and environment—or nature and nurture—to gain scientific expression and legitimacy, in ways that emphasized the importance of the childhood environment as especially pertinent to the biopolitical imperative of producing a healthy, productive workforce of the future (Chödrön, 2015; Murray, 2015).

However, beyond these expert fields, the practice of ranking based on "stunningly precise" visualizations of how "neighbourhoods are faring" (Boyle, 2014) has become increasingly normalized in the production and circulation of images of cities and neighbourhoods through magazines; social service organizations; and the cutting-edge open data and analysis tool, Wellbeing Toronto, launched in 2011. The upshot is a constellation of sites through which this new urban spatial mode of knowing and managing life is dispersed: *Toronto Life* stokes the flames of gentrification and neighbourhood-level competition by producing a "definitive ranking" of Toronto's 140 official neighbourhoods. Mothercraft, a child welfare organization founded in Colonial New Zealand, collects and publishes data about Toronto neighbourhoods according to their "social risk" and "early childhood development" indices[1]. The Urban HEART @ Toronto project, a partnership between St. Michaels Hospital and the City, ranks all 140 neighbourhoods according to an equity benchmark.[2] Finally, Wellbeing Toronto disrupts the distinction between lay and expert uses of data by offering an interactive, user-based, open data mapping tool that anyone with an

[1] See Mothercraft. Riding profiles. Retrieved March 13, 2016, from http://www.mothercraft.ca/index.php?q=current-and-past-results.
[2] See Church, E. & Thompson, S. (2014, March 10). Toronto Neighbourhoods ranked by new 'equity score.' *Globe and Mail*. Retrieved from http://www.theglobeandmail.com/news/toronto/toronto-equity-score/article17401356/; and Toronto Social Development, Finance & Administration. (March 2014). TSNS 2020 equity index: Methodological documentation. Retrieved from http://www.toronto.ca/legdocs/mmis/2014/cd/bgrd/backgroundfile-67350.pdf

internet connection can use to produce neighbourhood rankings based on an assortment of non-standardized data curated through the City of Toronto's Department of Social Development.[3] These shifts bring neighbourhoods in general into visibility in new ways, as we can see with the case of Parkdale and Roncesvalles. These shifts illustrate how epigenetic norms are expressly or implicitly being adopted across very diverse fields of knowledge production, including a popular magazine, social services, medical institutions, and government bureaucracies.

How did we come to think of health in this way? What are the conditions of possibility for knowing and governing life this way? In order to answer these questions, the chapter consists of three main sections. The first traces the birth of epigenetic science in Canadian policy frameworks. The second discusses the broad contours of how the entry of GIS into the social sciences has allowed for new forms of measurements for tracking and mapping human geographies. The third shows how Toronto and its neighbourhoods are brought into visibility in new ways through the confluence of epigenetics and GIS mapping. I argue that this surfacing urban spatial mentality that emerged in the wake of the Lalonde Report aligns with the responsibilization of health at the individual level. However, it also draws considerations of local environments into the picture in novel ways because responsibilized health needs places, spaces, goods and, services through which to be enacted and preformed.

[3] See City of Toronto. (2016, May 8). Social development. Retrieved from http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=4209f40f9aae0410VgnVCM10000071d60f89RCRD

2. Population Health and the Birth of Urban Epigenetics

The buzzword of the 1990s was "globalization" (Smith, 2002). The term was meant to capture the extent to which the primacy of the territorial and spatial entities encapsulated by states was under pressure by economic forces that transcended national boundaries (Abu-Laban and Gabriel, 2002; Sassen, 2005, Smith, 2002). Gone were the old days of the "vertically integrated" national firm. In an effort to maintain profitability, manufacturing in the Global North engaged in mass layoffs and relocated production "offshore" to areas in the Global South where, due to historical experiences of colonialism and underdevelopment, large reserves of lower cost labour could be found (Harvey, 2005). In the context of these broad shifts, cities in the North came into visibility in new ways, as centres of capital accumulation based on the centralization of financial industries, research and development centres, and so forth. In this way, the global political economy was reterritorialized in ways that privileged "global" and transnational flows of people and goods, while simultaneously emphasizing the role of cities and city regions as the specific places where economic transactions took place (Sassen, 2005).

In this new economic climate cities were positioned relative to one another as competing directly for talent and resources, and national and local governments alike sought to cultivate "world city" status, by conforming to the presumed imperative to be "attractive" to the global creative class, which was seen as the human capital engine of urban and regional growth and capitalist prosperity (Florida, 2002, 2003; For a critique see, for example, Blomley, 2004; Kern, 2010; Valverde 2012). In Toronto, by the turn of the millennium this goal was explicit in areas of policy, ranging from culture industries to infrastructure to public health, at the local and regional levels (Gertler et al., 2002; Toronto, 2003, 2011). Thus cities became the sites of new forms of governmental interest and the health, happiness, and

productivity of the current and future urban populations and their newly ascendant knowledge economy workers (Chödrön, 2015; Murray, 2015; White, 2011).

It was in this broad context that epigenetics, a novel paradigm for conceptualizing the relationship between the urban environment and life-course development of current and future workers in the knowledge economy, entered the mainstream health sciences in Canada (Chödrön, 2015; Murray, 2015; White, 2011). Epigenetics—"roughly in addition to genetics" (Murray, 2015, pp. 283-84)—has become an emerging site of urban research into the "interface of our environment and our genes" (Francis, 2011). It has also been described as "a fashionable contemporary explanation for such seemingly random processes" as, for example, a lifetime smoker living to the age of 100 (Smith, 2011, p. 537). Urban epigenetics has been a focus for research interested in understanding a broad range of public health concerns including cancer, cardiovascular disease and obesity and mental health (Francis, 2011; Smith, 2011). *Environmental* epigenetic research aims to track the "mechanisms by which social forces—from pollution to nutrition to mothering to traumatic experience—become molecularly embodied, affect gene expression, and induce durable changes in behaviour and health" (Landecker and Panofsky, 2013). It has therefore become a science through which the relationship between the socioeconomic environment, defined as including the fetal environment, and early childhood development is studied (Evans et al., 1994; Francis, 2011; Lawson et al., 2015; Mothercraft, 2011; Urban Child Institute, 2012). In the case of the latter research agenda, the problem has been framed as one of understanding the correlations between geographic patterns of socioeconomic inequality and the social and physical environments of early childhood development.

The science of epigenetics allows researchers to imagine that they are precisely pinpointing the mechanism through which the human body and external environment are

related, and what effect this has on one's health over one's "life course." Thus, this type of research aims to "carve nature at the joints" by investigating, for example, which parts of the brain are affected by which aspects of poverty. Stated otherwise, the promise of epigenetics is that it can help researchers determine links between specific correlates of poverty, such as sub-optimal language acquisition, and the part of the brain responsible for this development, in order to imagine increasingly precisely targeted interventions: to "enable rationally designed, and therefore more effective, programs of prevention and intervention" (Farah 2011, p. 9).

The Canadian Institute for Advanced Research (CIFAR) was a key link in the mainstreaming of epigenetic frames into forms of urban governance. Specifically, in the early 1990s it spearheaded the epigenetic mode of conceptualizing the relationship between human health and environment took shape around a critique of the details of *how* the biology-environment link was formulated by the proponents of health promotion and the New Public Health.

2.1 The Canadian Institute for Advanced Research

CIFAR was a key space through which epigenetics entered mainstream policy frames in Canada, vis-à-vis the science of "population health," and later through "human development" (Chödrön, 2015; Hayes & Dunn, 1998; Murray, 2015; White, 2011). The CIFAR was established in 1982 by Dr. Fraser Mustard, Canadian physician and professor of epidemiology at McMaster University. The objective of establishing such an organization was to "create an international and multidisciplinary network of scholars working on complex problems of scientific, economic and social significance" (White, 2011, p. 222). The organization was "an independent 'think tank' loosely based on the Stanford Institute" (Hayes & Dunn, 1998, p. 8) and the Rockefeller Institute (Murray, 2015). The Institute, Dr.

Mustard, and those close to him have been instrumental in bringing population health and human development into governmental thinking and policy making at the federal government as well as in Ontario and British Columbia (Murray, 2015; White, 2011).

One of CIFARs "earliest projects was a population health program, which ran from 1987 to 2003" (Evans, 1994, p. 8). The population health program was established as a research program "with the aid of a venture capital grant from Manufacturers Life Insurance Company of Canada" (Evans, 1994, p. 8). As Dr. Mustard articulated it in the early 1980s, the overarching goal of initiating a teaching and research program in "population health" was to intervene in the status quo of the health sciences. Specifically, the aim was to shift emphasis away from individual health problems and towards "the social and economic forces that shape the heath of citizens" in ways that are visible specifically at the level of the group or population (Hayes & Dunn, 1998, p. v). Population health was thus imagined as building on "a long tradition of public health and health promotion" while going "beyond the traditional focus on the individual as the medical, biological or lifestyle problem" (Hayes & Dunn, 1998, p. v).

The formulation of this problem space can be traced to a graduate seminar in Health Sciences that Mustard offered at McMaster University in the spring of 1983 (Hayes & Dunn, 1998, p. 7). For Mustard, a basic flaw in prior thinking was that health sciences began from the problem of "how to care for individuals who already have a health problem." As a corrective to this, he sought to introduce the "power of modern epidemiological techniques" to the study the health of populations in order to determine the "social cultural and economic factors that make individuals susceptible to abnormal health" (Mustard, cited in Hayes & Dunn, 1998, p. 7). In particular, Mustard's course brought clinical epidemiology to bear on economic and demographic approaches to the study of health problems:

> unfortunately, the study of health problems in populations, particularly from the standpoint of economists or demographers, has not usually used the power of modern epidemiological techniques. The linkage of these techniques to the study of these problems should greatly enhance our ability to sub-define the key components of social, cultural and economic factors that make individuals susceptible to the development of abnormal health. Further enhancement of information in this area will give society an increased choice of whether it wishes to develop strategies to intervene with social and economic problems from the standpoint of prevention to modify the impact of cultural, economic and social factors on the health of populations or whether we would prefer to increase the services of human care for individuals whose health becomes abnormal as a consequence of their genetic makeup and the environment in which they live. (Mustard, cited in Hayes & Dunn, 1998, p. 7).

As the CIFAR developed, it was (and still is) organized around research themes and constitutive sub-themes. The Population Health Working Group was one of 10 of working groups, organized under three broad categories, which constituted the activities of the CIFAR in the 1990s.[4] Mustard continued to be highly involved in the development of the population health approach. In its early days the CIFAR population health research program met 3-4 times a year for several years under the leadership of Mustard, who was at the time also the chair of the Population Health Advisory Committee, as well as founder and president of the organization (Evans, Barer & Marmor, 1994, p. xi). Members of the CIFARs population health group comprised "an interdisciplinary group of economists, health policy analysts… epidemiologists, social scientists [and] a geneticist" (Frank, 1995, p. 162). Self-proclaimed as a "diverse" (Evans, Barer & Marmor, 1994, p. xi) group of researchers, critics nevertheless argued that the range of views and methods represented was in fact rather narrow (see Coburn & Poland, 1996). In 1994 the group published the fruits of this collaboration, a collection of essays entitled, *Why are some people healthy and others are not?*

[4] These broad categories, and their constituent sub-categories, were 1) individual and society health and wellbeing including a) population health, b) economic growth and policy, c) human development, and d) law and the determinants of social ordering; 2) science relevant to the physical and biological origins and preservation of our planet, including a) cosmology, b) evolutionary biology, and c) earth system evolution; and 3) science with major technological potential, including a) artificial intelligence and robotics, b) soft surfaces and interfaces, and c) superconductivity (Frank, 1995, p. 162).

The determinants of the health of populations (Evans, Barer & Marmor, 1994). This book was to become a key text in the spread of "population health" as an organizing motif for research, social policy, and everyday health "common sense" in Canada.[5]

2.2 Population Health and the Critique of Lalonde

The population health paradigm emerged in large measure as a critique of the health promotion perspective advanced by the Lalonde Report. In particular, population health researchers affiliated with the CIFAR argued that health promotion was characterized by a scientifically naïve and unsophisticated understanding of the relationship between "health" and "environment." However, population health also benefitted from a broader interest in "health beyond health care" that was opened up by the Lalonde Report and New Public Health movement that it spawned. The methodological preference for epidemiology on the part of those sympathetic to population health in debates with health promoters was key. On the one hand, the application of epidemiology in the absence of an attempt to explicitly theorize 'the social' led to an "individualization of disease" phenomenon, while steering clear, or appearing to steer clear, of the "blame the victim" problem which had plagued the uptake of Lalonde by insisting that measures and interventions target populations, not individuals.

The work of the CIFAR's Population Health Working Group, published in *Why are some people healthy and others are not?* (Evans, Barer & Marmor, 1994), was inspired by the first and second Whitehall studies of the health of British civil servants, published in 1978 and 1991 (Marmot et al.). These studies identified a "persistent and consistent gradient in health" and concluded that position within the "social hierarchy" is *the* salient factor in explaining the

[5] This, incidentally, was published in the same year as the first edition of *Health promotion in Canada*, which was to become a major text in the undergraduate training of health promotion practitioners, and is now in its third edition.

large observed differences between health outcomes for "top" and "bottom" people (Evans, 1994, pp. 3-24). Moreover, because Marmot had studied civil servants, this research showed that gradients in health exist "independent of deprivation."

> Thus a common interpretation of the correlation between socioeconomic status and health–that 'the poor' are deprived of some material conditions of good health, and suffer from poor diet, bad housing, exposure to violence, environmental pollutants, crowding and infection–cannot explain these observations. (Evans, 1994, p. 5)

For Evans et al. (1994), the Whitehall studies also provided further evidence that the expansion of "universal access" health care systems in societies such as Canada and Britain, and the increased use of health services which followed, had not decreased health inequities: "the longitudinal data from the United Kingdom show no evidence that the introduction of the National Health Service has reduced the mortality gradient" (Evans, 1994, p. 10). While health care services are thus still needed, since they can "be decisive in individual cases, the availability of such services–or their lack–cannot begin to explain observed differences among the health of populations" (Evans, p. 4). Population health thus emerged as a science for attempting to explain and address the "persistent and consistent" inverse relationship between health and social status as documented in the Whitehall studies.

In framing the overarching problem of the Population Health Working Group in terms of an understanding of the biological pathways through which "position in the social hierarchy" manifests, Evans (1994) noted that the observation that poverty is bad for your health is not new (p. 3). However, they also asserted that the observation that health outcomes correspond to certain "well defined" populations, *was new*:

> the correlation between social status and health is only one leading example of a much larger class of observations, of large differences in health status, not just among individuals, but among well-defined groups: populations and subpopulations, both human and animal. Such aggregate observations…"heterogeneities"… lead naturally to attempts to identify the group characteristics associated with good and bad health, in the hope of finding and then influencing the underlying causal factors. (Evans, 1994, pp. 3-4)

Equally interesting is the way that Evans (1994) presents the significance of the research findings vis-à-vis "right" and "left" perspectives on health policy: "For some (on the right), 'the poor ye have always with ye'. One can never remove social differentiation…. Health differentials are thus inevitable (and probably deserved)…. For others (on the left), health differentials are markers of social inequality and injustice more generally, and are further evidence of the need to redistribute wealth and power, and restructure or overturn the existing social order" (p. 6). Yet, Evans continues, both "preconceptions miss the main point of Marmot's findings, that there is *something* that powerfully influences health and that is correlated with hierarchy per se. It operates, not on some underprivileged minority of 'them' over on the margin of society, to be spurned or cherished depending on one's ideological affiliation, but on all of us. And its effects are *large*" (p. 6, emphasis in original). As CIFAR-affiliated researcher John Frank elaborated in an *Ideas* radio documentary about the determinants of health, "it is as if the presence of many especially poor [people] effects the overall health of the population disproportionately, above and beyond the number of poor and their health status that is generally always worse than that of the wealthy in every population ever studied" (Frank, cited in Silversides, 1996).[6]

Thus, for Evans et al. (1994) the Whitehall findings meant that health policy needed to undergo a major rethink. Even though the Lalonde Report had been bound up with a broader social questioning of the extent to which traditional medical care was a determinant

[6] "The Health of Nations" was an *Ideas* radio documentary prepared by Ann Silversides based on the research of the population health program of CIFAR. It aired on November 21, 1996, and featured interview segments with CIFAR-affiliated researchers. In it, Clyde Hertzman introduced the idea of population health by stating: "Increasingly the evidence is showing that the social environment, in terms of the national socio-economic environment, income distribution within society, the quality of civil society, the quality of the institutions that we confront on a day to day basis, the quality of family support networks and local community support networks, and finally the quality of early childhood experiences all combine together to effect a health status in ways that are probably more powerful than any of the other competing risk possibilities such as health care, such as environmental pollution, or for that matter even individual health habits."

of health, there had "been no serious attempt since the Lalonde Report of the mid-1970s to bring this literature together and attempt to make sense of it within a *unifying conceptual framework*" (Evans, Barer & Marmor 1994, p. xii, emphasis added). This reexamination was to take two main directions: first "the measurement of health at the population level, and the development of extended and improved data systems, to permit us to know with more precision how our health is evolving and what factors are affecting it"; and second, to develop an improved understanding "of the role of the formal health care system–both its strengths and its limits–as a vehicle for mobilizing our resources to improve our health" (Evans, Barer & Marmor, p. xi). The argument put forth by Evans et al. took shape around a sustained examination of the need for greater understanding of the "causal factors" such as status, empowerment, stress, and coping skills shaping the "gradient in health," as well as the specific "biological pathways" through which these factors act on the body to produce differential outcomes through which health, disease, and illness manifest (Evans, 1994, p. 12).

In the book's second chapter, "Producing Health, Consuming Health Care," Evans and Stoddart lay out the specific contours of how and where the population health perspective converges with and diverges from the *New Perspective* offered by Lalonde two decades earlier. They praised Lalonde's white paper for its "four-field framework," which conceptualized the determinants of health in a manner that was "broad enough to express a number of the concerns of those trying to shift the focus of health policy from an exclusive concern with health care." Thus, "at very least the 'health field' framework emphasized the centrality of the objective of *health*" and acknowledged that, health care was only one among various types of policy that might advance that objective (Evans & Stoddart, 1994, p. 41).

However, Evans and Stoddart (1994) were nevertheless critical of the Lalonde Report and its impacts on several counts, arguing that the breadth of the "health field" notwithstanding, the impact of the *New Perspective* was to re-centre attention on individuals, lifestyles, and biomedical approaches to health and illness. Ultimately, this had the effect of allowing broader factors shaping health outcomes to remain obscure from the vantages of research and treatment: "Whatever the original intent, however, the white paper led into a period of detailed analysis of *individual* risk factors, i.e., both individual hazards and individual persons as contributors to 'disease' in the traditional sense. The potential significance of processes operating on health at the level of groups and populations was obscured, if not lost" (p. 42). For population health researchers the "individual" was simply the place where economy and biology met. Interventions leading back to individuals could never solve the social gradient puzzle, and research and programming needed to be oriented accordingly towards higher levels of economy and society, or lower levels of cells and genes. As Evans argued, "the questions raised" by the study of the determinants of health of populations

> take one from the society-wide to the subcellular level and back again, from economic and social policy to molecular biology. The individual person represents the point of contact between cellular and social aggregates. Determinants of health must ultimately show their effects on particular individuals, but their origins may well be 'above' or 'below' the individual level – mass unemployment say, or genetic predisposition. (Evans, Barer & Marmor, 1994, p. xi)

Evans and Stoddart (1994) further argued that, if anything, the "individualizing" effects of the New Perspective had in some ways deepened and extended the conventional biomedical emphasis on the relationship between the individual and her health care provider: "The focus on individual risk factors and specific diseases has tended to lead not away from but back to the health care system itself" since, within the existing health care system, "Interventions, particularly those addressing personal life-styles, are offered in the form of 'provider counseling' for smoking cessation, seatbelt use or dietary modification" (p. 43).

Moreover, this emphasis on "individual risk factors and particular diseases has…served to maintain and protect existing institutions and ways of thinking about health" insofar as the "broader determinants of health" continued to be seen as primarily "matters for the attention on individuals, perhaps in consultation with their personal physicians, supported by poster campaigns from the local public health unit" (p. 43).

> The net result is that the "'product line' of the health care system" is thus extended to deal with a more broadly defined set of 'diseases': unhealthy behaviours. The boundary becomes blurred between, e.g., heart disease as manifest in symptoms, or in elevated serum cholesterol measurements, or in excessive consumption of fats. All are 'diseases' and represent a 'need' for health care intervention. Through these processes of disease redefinition the conventional health care system has been able to justify extending outreach and screening programs, and placing increased numbers of people on continuing regimens of drug therapy and regular monitoring." (p. 43)

2.3 Stress, Epigenetics, and the Significance of 'Social and Cultural Environments'

The CIFAR population health perspective thus shared with health promotion a broad interest in pushing health policy "beyond health care" into the wider social arena: "the ultimate objective of health-related activity is not the reduction of disease, as defined by the health care system, or even the promotion of human health and function, but the enhancement of human wellbeing" (Evans & Stoddart, 1994, p. 53). Population health also shared the health promotion objective of identifying and strategically targeting "at risk" groups such as children and youth, and the interest in understanding environmental dimensions of this "risk." However, the population health perspective was explicitly critical of the former's conceptualization of the problem. What emerged from this critique was a focus on a much earlier period of human life as the primary target for risk management, and, with it, an emphasis on the emergent science of epigenetics.

Evans et al. (1994) were quite critical of what they saw as the "naiveté" of health promotion, especially as it had been taken up in the discourse of "healthy public policy" and attendant expressions in "healthy cities" and "healthy communities" discourse and policy. As

Hayes and Dunn (1998) write, Evans et al. sought to replace the logic of "more parks and municipal governance" with a(n) (more rigorous, in this view) emphasis on the significance of early brain development for understanding the "specific biological pathways" through which social environments determine health (p. 18). Population health, by contrast, brought the "power of modern epidemiological techniques" (Hayes & Dunn, 1998, p. 7) to the problem of understanding the "plausible biological mechanisms" (Evans, Hodge, & Pless, 1994, p. 162) through which social and physical environments impact biological beings.[7] As one reviewer summarized:

> The book's central argument is based on a synthesis of evidence – both familiar and newly emerging – suggesting that 'factors in the social environment, external to the health care system, exert a major and potentially modifiable influence on the health of populations, through biological channels that are just now beginning to be understood'. Recent scientific advances show ways in which people's perceptions of their social environments can stimulate chemical and electrical responses in the body's endocrine, immune and neural systems. These new studies lend credence to older ones that have emphasized the health promotion qualities of social support. (Judge, 1994, pp. 154-55).

Against this backdrop, early childhood was identified as an "at risk" group/life period, because it is a time when these systems, especially the brain and the neural system, are being developed, with potential implications throughout the life course. This contrasted with Lalonde's reasoning, which understood early life as a crucial period when *behaviour patterns* are adopted, which tend to follow people throughout the life course, thereby affecting or determining future health outcomes. In other words, where Lalonde emphasized *ethos*, population health emphasized *bios*.

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[7] It is not always clear whether the research being synthesized involved humans or research involving other animals, such as rats and non-human primates. However, Evans et al. (1994) were keen to emphasize the similarities between humans and other animals, especially "other primates." In establishing the importance of stress as a causal factor, in the Introduction to the book Evans writes: "a dominance hierarchy is readily identifiable among male [Kenyan olive] baboons, and… there are, on average, significant differences in the functioning of their endocrine systems…. Top baboons thus cope with stress better than their subordinates, who seem to be in a continuous state of low-level readiness or anxiety" (1994, pp. 12-13). In Chapter 5 we will see how this kind of language, in relation to humans, has been picked up by some in the new wellness industries.

The CIFAR Population Health Working Group was therefore very interested in neurological science and research pertaining to the relation between stress, brain development, and health outcomes throughout the life course. In particular, early research focused on the impacts of cortisol, a chemical produced as part of the body's physiological response to stress, on both early brain development and the aging brain (Evans, Hodge, & Pless, 1994; see also Hayes and Dunn, 1998; Judge, 1995).

In a chapter on epigenetics, "If not genetics, then what? Biological pathways and population health," Evans, Hodge and Pless (1994) sought to understand and name the "*something*" that Whitehall documented, which produces group effects in health outcomes. They wrote that "although this evidence is compelling, it would be even more convincing if one could picture plausible biological mechanisms or processes producing such effects…" (p. 161). Further, while some biological pathways are well known, such as poor nutrition and "crowding," which enables the spread of airborne infections more rapidly, others are less well understood. "Considerable evidence is now accumulating that offers an outline, if not a full picture, of some of the underlying biological pathways, not just related to smoking or crowding, but for the much more subtle effects of social and cultural environments." They thus present the chapter as a review of "current understanding of relevant phenomena at the cellular or subcellular level within individuals" (p. 162).

"Stress" and its presumed antidote, conceived as "coping," took center stage here: "Keys to understanding the biological pathways through which environmental and social factors have their effects may be found in the ways in which humans and other primates respond to stress. Particularly sources and forms of stress may be surmountable or overwhelming in different individuals, or in different circumstances" (Evans, Hodge, & Pless, 1994, p. 162). The authors of this chapter noted that, beginning in the 1960s, research

into the effects of stress found their way onto the radar from research that was then being pursued into the role of families in the occurrence of disease: "Viewed historically it appears that the concepts of stress and coping became prominent at about the same time that many, especially medical sociologists, were focusing increasingly on the role of families in influencing the health of their members" (p. 163). They also noted that "Invariably, these studies focused on the tension between the external stresses faced by the individuals, and their 'coping' responses. Stated simply, it was postulated that stressful events result in strain, but that this can be reduced or reversed when effective coping mechanisms are brought into play." Here, coping was defined to include "ways of accepting, tolerating, avoiding, or minimizing stress as well as its more traditional sense of mastery over the environment. It is not limited to successful efforts, but includes all purposeful attempts to manage stress regardless of their effectiveness" (p. 163). Importantly, the authors acknowledged that initially this research into stress and coping did not lead to very promising results. Nevertheless, continuing interest in these subjects may be beginning "to pay off." In particular, Evans, Hodge & Pless (1994) cited then-emerging research on the complex interplay of "elements of the immune, neural, and endocrine systems" which determine the reactions of bodies to stress: "Over the last few decades, advances in immunology and neuroscience have led to a clearer characterization of the connections among these systems, shedding light on possible mechanisms by which the host response to environmental insults and stresses is mediated" (p. 163).

This is particularly significant in the context of increasing interest in and attention to neuroplasticity and the effects of "fight or flight" response, not only on early brain development, but also on brain health throughout the life course:

> The [human] organism is born with a substantial degree of flexibility in its neural capacities and adapts these in response to the external signals it receives early in life.

> It can thus cope successfully with a wider range of environments than if it were born with all its neural capacity preset. But if the early environment is 'information poor' and the signals received are limited or destroyed, then the neural development will be also…. The observation that there are particular 'windows' in the development of the neural system presumably comes as no surprise to students of language, who have known for some time that there is a critical period early in life during which language is normally acquired, rapidly and easily…" (Evans, Hodge & Pless, 1994, p. 172)

The authors further noted: "it appears that learning capacity may be affected by the response to stress." This is important since neuroplasticity is good for learning; however, that same plasticity also renders neurons more susceptible to stress. So, while information-rich environments are good for developing coping skills that will be conducive to (brain) health over the life course, stress in early childhood can impede the development of neuronal pathways essential to the development of "coping" abilities. This would, presumably (as long as rats are assumed to be an adequate stand-in for humans) contribute to a kind of "multiplier" effect: stressful environments in early life impede the body's ability to develop the capacity to cope with stress later on.

The authors (Evans, Hodge, & Pless, 1994) also point to research suggesting "processes are at work that involve the inactivation of neurons" at both ends of the life course:

> Early in life the sculpting out of the functional neuronal pathways, in response to experience and activity, implies the determination of which connections will not be made. At this time the more 'plastic' neurons, which are critical to the networking/learning process, are relatively widespread in the brain. But as the organism ages they become more concentrated (though not exclusively) in the hippocampus, which is also the location of the feedback process that regulates cortisol production… Supportive experiences at the very beginning of the life cycle confer significant benefits at the other end–for rats." (pp. 173-74)

It now becomes possible to define health risks and opportunities in terms both of early childhood experiences and optimal brain development. These are then connected to a range of risks, such as hypertension, coronary heart disease, and premature aging, through the twin

motifs of stress and coping and their effects on the brain throughout the life course. Thus the study of the determinants of health can parsimoniously "home in" on this period of life in an attempt to understand how social and cultural environments shape and inform how "individual organisms"/"hosts" perceive and respond to external challenges and the stress they produce. How can better knowledge be produced about these phenomena so that effective *health policy* interventions can be designed to shift the nature of the stress-coping tension/relation in the balance of improved health outcomes, i.e. improved morbidity and mortality. Thus, the problem is defined as one of understanding the "general" etiology of the social upon the biological, such that appropriate interventions can be made. But whether the key policy implications that would emerge from this would be targeted at "the social" or the "biological," or indeed what the distinction would be, is never unpacked.

Importantly, this emphasis on "coping" as an interesting and research-worthy subject fits with the overall suggestion that the status quo of both "right" and "left" perspectives on health policy and health research leave much to be desired. On the one hand, the right-wing or "do nothing" perspective misses the opportunity and imperative to use knowledge to produce more optimal human responses and more optimal human beings. On the other, left-wing perspectives, in this line of argument, are suggested to be targeting resources in the wrong places and in the wrong directions: since hierarchy "affects us all" the redistribution of resources cannot do much. The suggestion that seems to be made is: why try to change society when we can –theoretically– achieve more by modifying human responses to the stress of hierarchy?

The emphasis on young people from the line of inquiry drawing on epigenetics contrasts with Lalonde's emergent emphasis on young people as key at-risk populations. For Lalonde, the social conditions, behaviour patterns, and decision making that follow young

people into their later years are formed during youth. Youth is therefore an important part of the life cycle that determines future health behaviours and outcomes. Evans et al. (1994) were critical of Lalonde for not paying much attention to the epidemiology or the specific biological pathways, that is, for emphasizing ethos over bios. For Lalonde, it was ultimately a choice—in the context of varying degrees of "freedom," to be sure—but nevertheless choice was seen as a key hinge on which social differences in health outcomes are determined. In Evans et al. (1994), by contrast, the significance of the early period of human life was conceptualized in terms of neuroscience and neuroplasticity. Because the young brain is both full of neurons looking to develop pathways based on early learning experiences, and because neuroplasticity renders neural pathways especially sensitive to hormones associated with stress, this period of life was identified as precisely the kind of etiology needed to account for the persistent and consistent gradients in health status they were concerned with.

This is very different than the "peer-pressure" argument put forth by Lalonde when he argued that youth ought to be considered an "at risk" category for cardiovascular disease, since youth is a period when "healthy" or "unhealthy" behaviours such as smoking are shaped and carried into adulthood. Evans et al. (1994) saw Lalonde's characterization of how "environment" could determine health as naïve and simplistic. By contrast, the line of inquiry developed by the CIFAR population health group sought to complexify this argument and its main assumptions, though not by introducing a sophisticated or nuanced theory of "society" or what the key factors producing or constituting a "population" with similar health risks might be. Rather, the complexity that Mustard and the CIFAR introduced was rather more a biological and biomedical complexity, which focused on the physiological responses of non-human and human animals to forms of stimulus associated with stress responses to one's position in a given hierarchy.

The Evans et al. book (1994) was well received by some in the public health community, and critiqued by others. Some saw the book as reaffirming the public health emphasis on the "big-stuff" (i.e. socioeconomic factors) as important determinants of health and argued that the population health perspective represented only minor adjustments to the Lalonde perspective, and/or noted that it added "legitimacy" to earlier emphases on the social causes of ill health (Frank, 1995; Hayes, 1996; Judge, 1994; Labonté, 1995; Wigle, 1995). However, initial critiques of the population health research program as articulated by Evans et al. in 1994 highlighted both its lack of engagement with the key sociological concepts from which it purported to draw, such as "society" and "inequality" (Coburn & Poland, 1996; Labonté, 1995), as well as the "placeless" and "spaceless" nature of its analysis (Hayes, 1996).

Critiques of the book generally focused one or more of three main issues. The first was that the methodological emphasis on epidemiology was tantamount to a "re-medicalization" of health promotion (Labonté, 1995). The second was that the "social" in the social determinants of health was not theorized, but merely assumed to be something like a placeless and spaceless aggregate of people, with the implication that while "social" factors such as class or income inequality could be named, they could not be explained, nor did they appear to demand explanation (Coburn & Poland, 1996; Hayes, 1996; Labonté, 1995). The third, which follows from the previous two points, was that the pretense towards positivist and empiricist modes of knowledge production hid an implicit but unstated theoretical preference for macroeconomic policy fixes, promoting the generation of wealth (Coburn and Poland, 1996; Labonté, 1995).

In fact, in the discussion of the determinants of health in Evans et al. (1994) the term "social" does not appear to be a qualifier (see Orsini, 2007 on this point). Yet, throughout

the book "the social" was directly linked to the body's biological processes. The primary relationship was that between the following three things: "social hierarchy," conceived of as a more or less static entity; the biological systems of the body; and the ways in which these systems respond to stimuli associated with hierarchy and inequality, such as stress and the production of cortisol. The importance of the social is conceptualized in terms of "host response": how does the individual respond *at the biological/subcellular level* to social forces or "facts" such as hierarchy? Similarly, the notion of a "group" or "population" was not, in itself, unpacked or theorized (Labonté, 1995). It seemed to be taken for granted that the emphasis on "group" characteristics followed first from the "data" and second from the analysis which identified "hierarchy" as the likely cause. As Coburn and Poland (1996) argued:

> it is suggested that, because 'prosperity' and economic development are related to the health status of populations, we should focus attention and resources on the 'wealth producing' aspects of the economy–this based on Adam Smith's distinction between 'wealth producing' and 'wealth absorbing' parts of society. What is implied is that… we should focus on 'wealth production' and expect population health through a 'trickle down effect.' (p. 309)

In the population health account offered by Evans et al. (1994), social forces act directly on the biological processes of humans, and while they act disproportionately on the bodies of some humans relative to others because of place in the social hierarchy, they do so "independently of deprivation." While for some this was flagged as problematic because it was seen as re-individualizing the problem of health along biomedical lines, for those who received the book positively, it was a major step forward, and an exciting incentive to further research. Moreover, the suggestion that the ways in which place in the hierarchy affects biological development at the beginning of the "life cycle" was taken up with particular enthusiasm. Because illness was conceived as a being "determined" by the biological response to social stimulus associated with "position in the hierarchy," the possibility of

altering both social stimulus and biological response to it from a young age emerged as a new research possibility at around this time (see Murray, 2014, 2015). As Hayes and Dunn (1998) summarized Evans et al. (1994):

> Early Childhood is a crucial window of opportunity for the development of intelligence and coping skills because is it then that the fundamental neuronal pathways are developed. As the number of connections made in the brain increases so does the potential for processing information. Taken together, the mechanism of social stress leading to potentially damaging biological responses is consistent with the known distributions of stresses among different groups in the social hierarchy and related health status gradients…. (p. 17)

2.4 Becoming a Spatial Science: Population Health, GIS, and Early Brain Development

Over the course of the 1990s population health emerged as a major theme of health research and social policy reform in Canada (Chödrön, 2015; Hayes & Dunn, 1998, p. 1; Tite, 2008). In 1993 the CIFAR launched a human development research program, which stemmed directly from its work on population health (White, 2011).[8] A key output of the CIFAR human development research program was the Early Development Instrument (EDI). The EDI was "designed as a survey tool to assess children's development vulnerabilities" and was formalized in 1997 and copyrighted in 2000 (Murray, 2015, p. 284). The EDI formalized the assessment of brain development concerns identified above, and was comprised of "roughly of 104 questions relating to 'physical health and wellbeing; social competence; emotional maturity; language and cognitive development; and communication skills and general knowledge in relation to developmental benchmarks rather than curriculum based ones'" (p. 284). According to Murray:

> At the heart of this surfacing sphere of research, policy and programing was a central question that was succinctly expressed in the learning society: 'What are the basic needs for positive human development?' This question presumed a divide between

[8] According to Murray the founding statement of CIFARs Human Development program took shape around two key documents: *The learning society: Proposal for a program in learning and human development* (CIFAR, 1992) and *Reversing the real brain drain: The early years study final report* (McCain & Mustard, 1999). The Mike Harris government in Ontario commissioned the latter document (Murray, 2015, pp. 281-82).

> the optimal and the sub-optimal human, the former the bedrock of wealth stability and order, that latter a threat to these qualities. The optimal human had an 'informed lively and engaged mind' and was imbued with 'rationality, skill, intuition, civility, character [and] values'. The suboptimal human was implicitly defined as the opposite: irrational, lacking intuition, uncivilized in character and values, and importantly, a threat to future productivity." (Murray, 2015, p. 282, citing CIFAR)

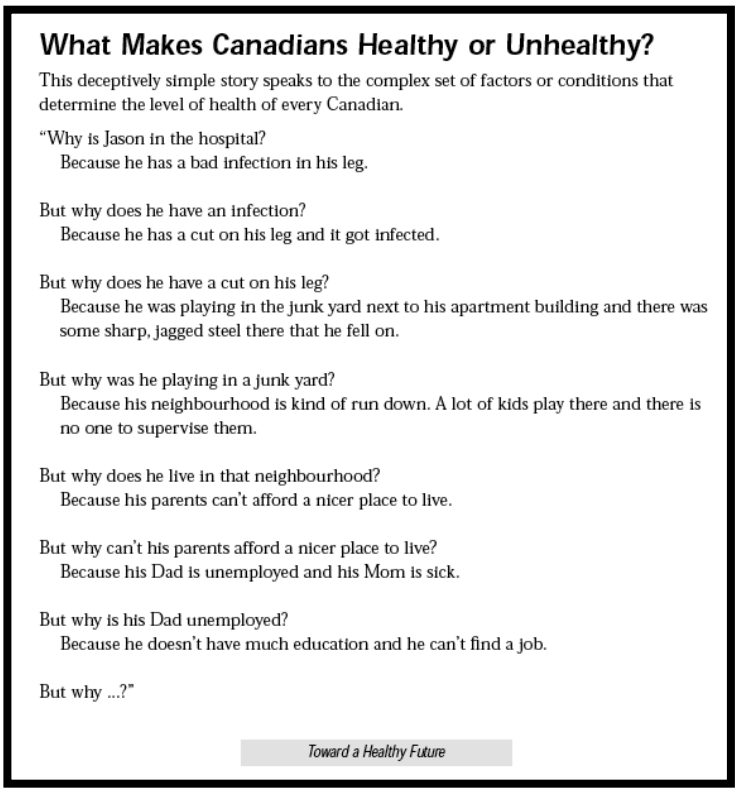
The population health-human development focus on early childhood in particular gained momentum around concerns pertaining to economic globalization, the competitiveness of the Canadian economy, and the need to ensure the maximum productivity of the Canadian workforce (Chödrön, 2015; Murray, 2015; White, 2011). Early childhood was therefore a key moment in two respects: first, because the mass entry of women into the workforce and the restructuring of the single wage-earner model presented new challenges for social reproduction, and the care and education of infants and children in particular (White, 2011); And second, early childhood was conceptualized by the emerging science of population health as a crucial moment for ensuring that the children of today would become the "productive workers" (White, 2011) and "optimal humans" (Murray, 2015) of tomorrow.

CIFAR, Dr. Mustard, and those close to him are credited with bringing awareness of and interest in the emerging science of early human development and Early Childhood Education and Care (ECEC), to the "highest levels of the Canadian government" under the Chretien-Martin Liberals in the 1990s and early 2000s (White, 2011, p. 222). Officials were persuaded of the importance of early human development "through the scientific underpinnings of arguments as well as the grounding of ideas in human capital development concerns" (White, 2011, p. 221; see also Chödrön, 2015). The EDI has since become a key instrument, which, in conjunction with the capabilities of Geographic Information Systems/Science (GIS), is bringing neighbourhoods in Toronto into visibility in new ways.

In 1999 Health Canada released its *Second report on population health* (FPTAC on Population Health, 1999), which opened by explicitly linking health risks to localized spaces of socioeconomic hardship. The story about little Jason, reproduced in Figure 4.1 below, is taken from its opening pages. The early 1990s also saw the four "determinants of health" originally articulated by Lalonde expand to nine and 12, respectively (Tite, 2008). The language of the CIFAR population heath group is echoed in, for example, the inclusion of a new distinction between social and physical environments, income and social status, employment and working conditions, gender and culture, and in the broad emphasis on "stress" and forms of "coping", the latter of which displaced the language of "lifestyle" in phrasing such as "personal health practices and coping skills" and "social support networks" (Tite, 2008, pp. 11-15). In the "deceptively simple story" laid out below, Jason's health event is discursively "mapped" onto an abstract, general experience of localized economic insecurity. This insecurity and its connection to health is figured in the image of the father's unemployment, which in turn relegates "Jason"—and other hypothetical children like him—to playing, unsupervised, in a "junk heap."

Two years later, in 2001, Human Resources and Skills Development Canada published the results of the North York Community Mapping Study, which was commissioned as part of a broader effort to systematically map social risks onto childhood development in a selection of socio-economically marginalized communities across the country. That same year, an early EDI map was published in the *Vancouver Sun*. The map was produced as part of CIFAR-affiliated epidemiologist Clyde Hertzman's human development research (Murray, 2015). A former student of Frazer Mustard and "former key player in CIFARs population health program," Hertzman had received funding from "Human

Resources Development Canada and from the Vancouver Richmond Health Department for EDI mapping in Vancouver" (Murray, 2015, p. 285). Hertzman's remarks pertaining to the



What Makes Canadians Healthy or Unhealthy?

This deceptively simple story speaks to the complex set of factors or conditions that determine the level of health of every Canadian.

"Why is Jason in the hospital?
Because he has a bad infection in his leg.

But why does he have an infection?
Because he has a cut on his leg and it got infected.

But why does he have a cut on his leg?
Because he was playing in the junk yard next to his apartment building and there was some sharp, jagged steel there that he fell on.

But why was he playing in a junk yard?
Because his neighbourhood is kind of run down. A lot of kids play there and there is no one to supervise them.

But why does he live in that neighbourhood?
Because his parents can't afford a nicer place to live.

But why can't his parents afford a nicer place to live?
Because his Dad is unemployed and his Mom is sick.

But why is his Dad unemployed?
Because he doesn't have much education and he can't find a job.

But why ...?"

Toward a Healthy Future

Figure 4.1: Seeing Health in (hypothetical) Space. (Source: FPTAC on Population Health, 1999. Reprinted with permission from the Public Health Agency of Canada).

public reaction to these maps is instructive. He stated: "all hell broke loose. No one had ever seen a neighbourhood-by-neighbourhood map on the state of children's physical, social and emotional development or their language and cognitive skills." Moreover, the maps had a major impact because "people could see the information so clearly, and it represented their children, in their neighbourhoods, rather than a random sample of the population in a hypothetical neighbourhood" (Hertzman, quoted in Murray, 2015, p. 285). These comments suggest the power of the confluence of two expert techniques: first, the ranking and assessment of human development and "risks" to it; and second, the geo-coding of this information such that it can be represented in the form of maps, which are easy to read and

facilitate the connection of abstract data to the intimate spaces and experiences of daily life. Hertzman's remarks suggest the intuitive persuasiveness of seeing "real" health and development data mapped onto "real" neighbourhoods (Schuurman, 2004). The North York Community Mapping Study drew on and extended this insight into the subjectivation and responsiblization possibilities that inhere in the mix of population health and GIS. Thus by the dawn of the new millennium the new science of population health came to be increasingly tied to the techniques of mapping, ranking, and indexing local space. The development and dispersion of increasingly powerful Geographic Information Systems (GIS) for the collection, storage, and processing of detailed and geographically coded demographic information is an important part of the broader dissemination and normalization of this mode of producing knowledge, policy problematizations, and solutions to matters broadly related to health and urban governance.

Geographic Information Systems can be defined as "the mix of hardware, software and *practices* used to run spatial analysis and mapping systems" (Schuurman, 2004, 2009b, p. 279). Thus, GIS "does not refer to a homogeneous entity, nor one machine or a single practice but to a collection of practices, software and hardware with the ability to collect, store, display, analyze and print information about the Earth's surface (or any other scale of geographical data)" (Schuurman, 2004, 2009b, p. 279). GIS are therefore "uniquely integrative" and are better understood as "processes" of data storage and analysis than as software and/or hardware.

The production of maps as means of communicating and visualizing spatial data is only one of the many applications of GIS technology, and it comes with its own strengths and limitations. As Canadian geographer and GIS expert Nadine Schuurman notes, there was a time in the history of the development of GIS when there was there was a stricter

division between those using GIS to analyze data and those using GIS to map it. Those interested in highly technical and mathematical applications of the technology tended to be less favourable to map-based visualization, because it relied a lot on intuition, which remains a poorly understood aspect of cognition (Schuurman, 2004). However, the increasing popularity of GIS, and of mapping applications in particular, was highly valued by some experts precisely because of its retention of "subjective" dimensions of knowledge production:

> [GIS] has reinvigorated something that was in danger of becoming moribund. To take an example, the kinds of methods of spatial analysis that we were developing in the late 70s and 80s represented by geomathematical analysis were becoming very abstract and abstruse… GIS came along and initially the notion was that it would allow us to implement those methods and make them easier to use… In practice what happened is quite the opposite. GIS has reestablished the importance of intuition and simplicity of exploration over those very hard-core confirmatory hypothesis-testing techniques. (Goodchild, cited in Schuurman, 2004: 112).

Today, GIS has a wide variety of applications in government, academia, and the private sector, and has seen significant expansion and diversification since the 1990s. It also has proven tremendously powerful in its capacity to produce knowledge about the social as well as physical worlds (Schuurman, 2004, 2009). Municipal governments use GIS to store and analyze information pertaining to zoning, property tax, and physical infrastructure. In addition, the City of Toronto now uses GIS spatial analysis for social analysis and planning (Budic, 1994; Schuurman, 2004), and even hosts an annual GIS day to showcase this work (City of Toronto, 2017b).

Interest in and use of GIS in social science research is now a growing field Gooodchild, 2004; Schuurman, 2004).[9] Schuurman, who is also a population health

[9] Goodchild, M. F. (2004). *Social sciences: Interest in GIS grows*. Retrieved from http://www.esri.com/news/arcnews/spring04articles/social-sciences.html

researcher[10], writes, "GIS is enjoying a boom. It is increasingly recognized by disciplines outside geography, and, to many, epitomizes modern geography" (2004, p. 1). In the 21st century, the GIS "boom" manifests in the fact that

> software sales exceed seven billion US dollars annually; students flock to GIS classes in colleges and universities; on-board navigation systems are the mark of a luxury car, police officers are routinely trained in GIS; epidemiologists use GIS to identify clusters of infectious disease; archeologists use it to map sites; and Starbucks is reputed to use GIS to site its very successful coffee shops. (Schuurman, 2004, p. 1)

Furthermore, only a small amount of the potential for growth in this kind of research has been realized to date: "These are very early days in spatial social science. Only a fraction of 1 percent of the literature published in the social sciences takes a spatial perspective, so the potential for growth is still enormous…" (Goodchild, 2004). GIS, as a spatial tool, is represented as holding the clue to a riddle that has plagued the social sciences for years: "Despite decades of searching, social scientists are often frustrated by the evident lack of general, universal laws in social science–mathematical models that apply equally to human societies everywhere" (Goodchild, 2004). But, the combination of GIS and "spatial thinking" hold a "new and exciting" possibility: "that general principles might exist, but that their expression in different areas might be substantially different" (Goodchild, 2004). Yet while the technology is increasingly ubiquitous, "Technical advances in GIS have proceeded before our ability to realize and understand its potential effects" (Schuurman, 2004, p. 1). In the field of population health specifically, "a number of methodological contributions by geographers in the field of geographic information science (GIS)… have strengthened or offer the potential to contribute to the known empirical relationship between socioeconomic conditions and gradients in health" (Schuurman & Bell, 2011, p. 138).

[10] In establishing the basic definition of what population health is, what its methods are, and how it defines its problem space and the significance of its research findings, Schuurman cites the work of key members of the CIFAR population health group (i.e. Evans et al., 1994; Hertzman, 1999; Mustard & Frank, 1994), as well as the touchstone research that they built from (i.e. the Black Report) (see Schuurman, 2011, pp. 138-39).

Population health is a key example of where GIS processes are applied to identifying and addressing social "problems." How geographic representation, and GIS in particular, has become an important feature of the representational and methodological tool kit of population health research can be explained by developments internal to GIScience, and in turn, to population health research. GIS/GIScience has changed considerably since the early 1990s when population health was taking off; similarly, population health was changed considerably by the then-emergent possibility of incorporating GIS technology into its methodological tool kit.

Explaining that GIS contributes to the study of population health, Schuurman & Bell note that the thesis of population health research is built from "empirical evidence" that demonstrates that "the socioeconomically graded nature of health," which is linked not only to "individual social and economic circumstance," but also to

> the social and physical environment, so much so that that it is liable to change according to the neighbourhood where one lives. This latter finding is the primary emphasis of attempts to quantify the various effects of features such as feelings of safety, resource sharing… etc." (2011, p. 140)

Thus, population health is also related to "a resurging interest in quantifying the role of 'place' and the significance of intra-individual relationships in characterizing one's health." Furthermore, while "Health and the myriad factors that affect it including 'lifestyle', biological and psychological characteristics have long been under scrutiny within developed countries…. their combined influence has never explained why certain populations are healthier than others" (Schuurman & Bell, 2011, p. 138). This has led researchers to conclude "the structure of the social environment is likely the most profound means by which the health status of the general population is shaped" (Schuurman & Bell, 2011, p. 138). Schuurman & Bell therefore highlighted three ways researchers using "emergent GIS approaches to population health" are likely to impact the development of population health

research: first, how researchers "conceptualize neighbourhood influences on health"; second, how researchers "optimize the scale in which these processes are observed"; and, third, how researchers "construct benchmarks to quantify such relationships" (p. 138).

One immediate consequence of this relationship between GIS and population health knowledge production is a technical and ontological bias of scale: the appearance of a seemingly fundamental and inexorable relationship between health, wellness, and "the local." There are physical limits to "pages," both physical and virtual, which render the abstraction and reproduction of highly detailed information pertaining to the social attributes of space at small scales simply impractical. In other words, the type of detailed complex and granular information that makes it possible to present using GISystems can quickly overcrowd a map at a smaller scale (i.e. national, provincial, or territorial) (Schuurman, 2009, p. 279). The "local" appears increasingly as a logical application and outgrowth of massive data-generating capacity, and the ontological limits of how this can be represented. Thus, the power of this process for representing social phenomenon is best realized at a large scale (i.e. at the level of neighbourhood, region, or city). This does not mean that there are no useful applications for GIS outputs at a smaller scale; indeed, early Canadian efforts to develop GIS technology were specifically geared to the objective of representing national land use patterns (Schuurman, 2009). However, it does mean that the capacity to use GIS to "drill down" to a "granular level" in the analysis of social phenomenon is best showcased at a large scale, such as that of the city and its constitutive neighbourhoods.

This type of extensive, detailed visualization of the physical and social characteristics of neighbourhoods enables new ways of knowing and relating to space, not only for policymakers, but also for citizens at large. This, in turn, raises questions about how both specialist and "common sense" understandings of social space are defined and acted upon.

Are we to understand "healthy" and "unhealthy" neighbourhoods as discrete socio-spatial entities? Or are they fundamentally relational ideological constructs, produced through processes that span entire cities, city regions, or even the "global"? This ontological dimension of spatial knowledge production in public policy is an important dimension of the increasing policy emphasis on "communities" and "populations" in recent decades, and it has enabled forms of knowledge and modes of representation that are unique to our era. Consider, for example, the map in Figure 4.2 below, one of 33 similar maps published in the 75-page North York Community Mapping pilot project document, commissioned by Human Resources and Skills Development Canada (HRSDC) and aimed at describing and representing the social environment for children aged 0-6 (Connor, Norris, & McLean, 2001). In this context it is crucial to not to lose sight of the many decidedly non-local forces shaping health outcomes: if poor health is *localized* across various sites of knowledge production, then who or what can legitimately be called to account in addressing such localized health disparities?

3. Visualizing Toronto: Mapping, Ranking, and Indexing Local Space

This section documents the proliferation of "stunningly precise" (op. cit. Boyle, p. 144) representations of neighbourhoods as viewed through the prism of the social determinants of health, collected and compiled by teams of experts and presented to the public in the form of maps and indexes. I discuss three interrelated sites: The Canadian Mothercraft Society, Wellbeing Toronto, and the Urban HEART@Toronto initiative based at St. Michaels Hospital. This illustrates how population health and epigenetic norms are dispersed across very different sites: a popular magazine, social services, government bureaucracies, and a biomedical research centre. Furthermore, it shows the ways which epigenetic norms

bring the adjacent neighbourhoods of Roncesvalles and South Parkdale into visibility in distinct ways.

Recent years have seen a proliferation of efforts and instruments to rank, index, and benchmark local space according to criteria of health, wellbeing, and livability (Table 4.1, below). As deployed by the City of Toronto, HRDC/SDC, and their "partner organizations" such as Mothercraft, ranking, indexing, and benchmarking form a bundle of knowledge tools for "governing through the local." Indexes are produced such that people and places can be seen and known relative to one another, and these indexes are then both "benchmarked" and "bundled" to produce systems of ranking, for the purposes of determining where the most needy or vulnerable (Murray, 2004a) people and places are, and/or to "strategically target" investment in these people and places. The EDI, for example is an index that is "benchmarked" such that a definition of "low" can be produced through reference to the data, thereby producing its own intrinsic and seemingly natural categories of "normal" and "abnormal": "A neighbourhood is considered to have scored low on a domain if its proportion of low scoring children falls in the highest quartile of Toronto neighbourhoods" (Mothercraft, 2011). Thus, by definition, those spaces on the map that "fall into" a particular quartile are aberrant. Thus benchmarked, indexes can be used to generate "rankings" for the need or desirability of investment by various public and private actors.

Benchmarks must produce winners and losers. All units are ranked relative to the average of the group. Winners are thus defined as those that surpass the average to some degree, while losers are those that fall short of it by a similar mark. This is a process of normalization, of subjectifiation, and of producing standardized outcomes across a range of human endeavors, experiences, and forms of social organization. Moreover, it is not merely

about saying, "here is the norm, now conform." Rather, it is about producing a norm, which is a moving, open-ended target for optimization.

Table 4.1: "Best" and "Worst" Places to Live: Timeline of Select Place Rankings

Organization	First Year	Frequency of Ranking	Scale of Ranking
Mothercraft	2004	3-4 years	Federal Riding; Neighbourhood
Monocle	2006	Annual	City
Toronto Board of Trade	2009	Annual	City
Wellbeing Toronto	2011	On-going; User produced	Neighbourhood
Canadian Institute of Planners	2010	Annual	Neighbourhood; Street; Public Space
CBC "Crime Map"	2012	One Time	Neighbourhood
Toronto Life/Martin Prosperity Institute	2013	Twice, to date	Neighbourhood
City of Toronto/CRICH Equity Ranking	2014	One Time	Neighbourhood

3.1 The North York Community Mapping Study

The North York Community Mapping study was a pioneering study in the use of GIS techniques in a human development- and population health-oriented policy study. Sponsored by Human Resources and Skills Development Canada, the North York study was one of a series of "community mapping" studies pursued as part of a broader initiative called *Understanding the Early Years* (UEY), which used GIS to produce spatial knowledge about resources available to "school-aged children and their families" (SRDC, 2005, p. 2) in a selection of socio-economically marginalized communities across the country. The study was therefore part of the emergent "neuro-logic" (Chödrön, 2015) that positioned early childhood brain development as a core issue in the biopolitical imperative to generate an optimally healthy, productive, and globally competitive workforce (Chödrön, 2015; Murray, 2015).

The pilot for this series of studies took place in North York, Ontario in 1999 in the midst of the amalgamation that produced the contemporary boundaries of the City of Toronto (Connor, Norris, & McLean, 2001, p. 10). This section discusses the North York Community mapping study as an important site where population health research was joined to GIS-based spatial analysis, which, at the time, was making its own debut in social sciences applications as a distinct apparatus and procedure for producing geographic and spatial knowledge (Goodchild, 2004).

Coming on the heels of the "discovery" by population health and human development researchers affiliated with the CIFAR that early childhood is "a crucial window of opportunity for the development of intelligence and coping skills" (Hayes & Dunn, 1998, p. 17; see also Murray, 2015), the goal of the community mapping studies was to produce knowledge and capacity around the "influence of community factors" on child development (Connor, Norris, & McLean, 2001, p. 10). The community mapping study is thus part of a broader, emerging emphasis on "place based public policy" (Bradford, 2005; see also Murray, 2011), and is an example of how a population health-inspired emphasis on the significance of early childhood as a determinant of health is tied to federal efforts aimed at "constructing, shaping, mapping and visualizing communities as political technologies to align a wide range of individual action towards broader governmental goals" (Murray, 2004, p. 62). Through the mapping studies, efforts to produce highly detailed and "granular" information about the use and availability of resources for children in economically disadvantaged areas is also thereby joined to efforts to rank, index, and benchmark local spaces relative to one another. Again, as Murray writes, "While ostensibly devolving more control to local level groups and organizations," techniques such as these allow communities

"to be governed in new ways, according to logics of accountability defined in terms of explicit standards, performance measurements, and results" (Murray, 2004a, p. 62).

The North York Community Mapping study was significant for its early effort to systematically map "social risks" at the level of the census enumeration area in North York and other socio-economically marginalized communities across Canada. The output of this branch of the research consisted of 33 maps documenting various characteristics of the social and physical environment in North York, similar to the one reproduced in Figure 4.2 below, which shows North York Census Enumeration Areas (EAs) according the number of "social risks" found to be present in each.[11] Thirty of the maps where based on individual social or environmental attributes. These maps sought to represent diverse and detailed data about the lives of North York residents, such as which neighbourhoods contained highest proportion of families with children; which neighbourhoods had the highest number of people with a post-secondary degree or the highest number of recent immigrants; which neighbourhoods had the most litter, green space, or industry; and which had the highest concentrations of emergency services, arts and culture facilities, or recreational facilities (Connor, Norris, & McLean, 2001, pp. 8-9). The remaining three were synthetic maps that integrated multiple attributes into an index, including an environmental risk index (ERI), a social risk index (SRI), and an early development index (EDI). The "primary goal" of the SRI, the subject of the map pictured below, "was to present a comprehensive yet uncomplicated picture of the community's [i.e. North York's] socio-economic risk factors and to give an indication of the match of services to the needs of families and children"

[11] The authors define the relationship between enumeration areas (EAs) and neighbourhoods as follows: "Although there are numerous ways of defining neighbourhoods and communities, for the purposes of this report neighbourhoods will be defined and referred to using the geographical boundaries of Enumeration Areas (EAs)…. An EA… is the smallest standard geographic area for which census data are reported" (2001, p. 13). In 1996 the ratio of EAs to census tracks in North York was 795:111.

(Connor, Norris, & McLean, 2001, p. 63). The community mapping study is therefore an important touchstone both for its relatively early and extensive use of GIS mapping processes for social and policy analytical purposes, as well as for the nature of its output: maps, broken down to "neighbourhood"-level units and presented as tools for knowing, visualizing, and communicating information about the availability of resources for 'optimal child development.'

The UEY initiative was launched by the federal government in response to research such as that produced by the CIFAR's Population Health Working Group, which emphasized the significance of epigenetics and early childhood as determinants of health throughout the life course. This was also research that identified early childhood as a key period for the promotion of "optimal human development" in the service of the needs of a globally competitive knowledge economy (Murray, 2015).

> Developed by the Applied Research Branch (ARB) of Human Resources Development Canada (HRDC), *Understanding the Early Years* (UEY) emerged in response to a growing recognition that the kind of nurturing and attention that children receive in early childhood can have a major impact on the rest of their lives. Researchers have found that the early years of development, from before birth to age six, set the base for competence and coping skills that will affect learning, behavior and health throughout life. (Connor, Norris, & McLean, 2001, p. 10)

The UEY was a six-year "pilot" project, described as "a national initiative that provides research information to help strengthen the capacity of communities to make informed decisions about the best policies and most appropriate programs to serve families with young children." Moreover, the initiative "seeks to provide information about the influence of community factors on children's development and to enhance community capacity to use the data both to monitor early childhood development and create effective community-based responses" (Connor, Norris, & McLean, 2001, p. 5).

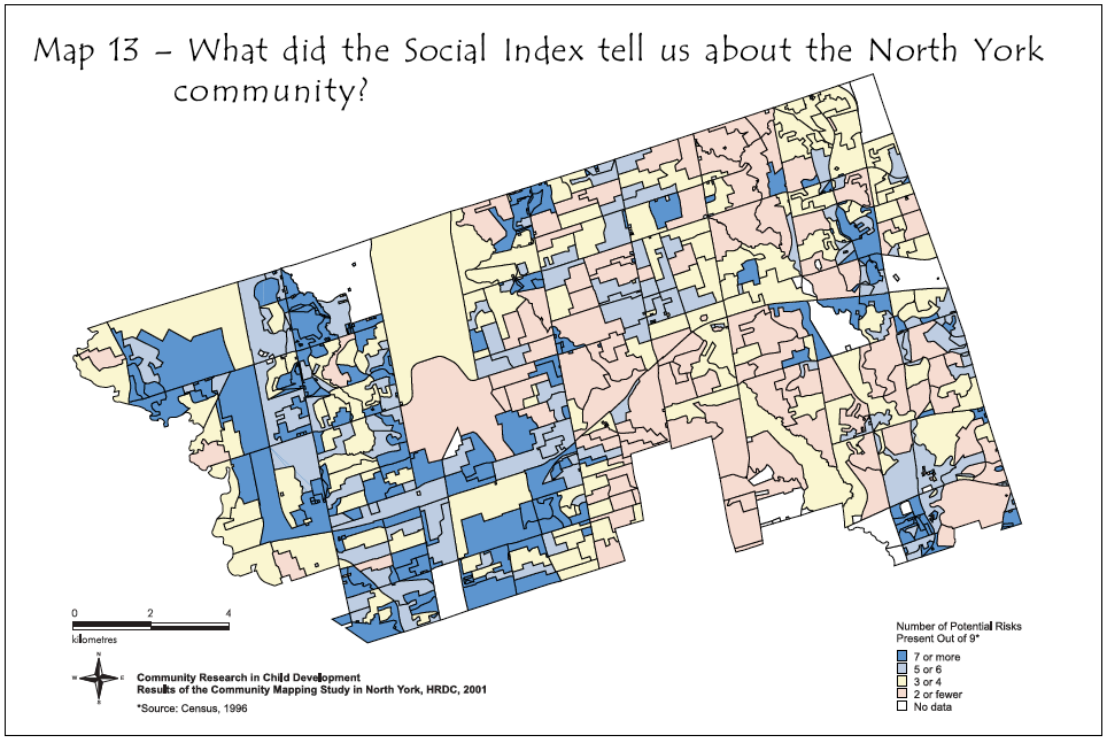


Figure 4.2: Abstract Intimate Space: Mapping Social Risk in North York. (Source: Connor, Norris and McLean 2001. Reproduced with permission of Employment and Social Development Canada (Formerly Human Resources Development Canada (HRDC)).

The project was carried out in a selection of identified communities across Canada: southwest Newfoundland; Prince Edward Island; North York, Ontario; Winnipeg, Manitoba; and Prince Albert, Saskatchewan (SRDC, 2005, p. 1).[12] However, North York was selected as the test site for the project and therefore research proceeded there first. In this sense North York was a crucial site for the development and testing of the UEY methodology, which relied extensively on the techniques of GIS analysis to produce knowledge about a spatially defined community, and was an early example of a social research project that could do so: "Community mapping is a relatively new and challenging means of communicating data. To date, very few social researchers have adopted it" (Connor, Norris, & McLean, 2001, p. 3).

[12] There was supposed to be one in BC as well, but it never went forward (SRDC, 2005).

The main objective of UEY was "to help determine the extent and nature of community influences on child development and how these might vary from child to child and community to community. In includes three independent but complementary data collection components, which allow for more detailed monitoring and reporting at the community level" (Connor, Norris, & McLean, p. 11). The three data collection components are (1) the Early Development Instrument (EDI), or "what we learn from teachers"; (2) The National Longitudinal Study of Children and Youth (NLSCY) community study in North York, or "what we learn from parents"; and (3) the Community Mapping Study, or "what we learn from community mapping" (Connor, Norris, & McLean, pp. 11-12).

In addition to being an early example of the use of GIS in population health policy research, the community mapping study is also significant for its element of "programmatic experimentation" (Murray, 2015, p. 279), which was evident in efforts to make its research results available and accessible to the communities in which the research took place; to determine how communities would use the information; and specifically, whether communities would use the information to engage in activities and programs that would "promote school readiness." According to Connor, Norris, and McLean, Understanding Early Years

> provides research information to help strengthen the capacity of communities to make informed decisions about the best policies and most appropriate programs to offer families with young children. It is designed to assist selected communities across Canada in achieving their goal of improving early childhood development by providing them with the necessary information to enhance or adapt community resources and services. *It gives communities knowledge of how childhood experiences shape learning, health and well-being, allows them to track how well their children are doing, and to optimize child development through the strategic mobilization of resources and programs*." (Connor, Norris, & McLean, 2001, p. 10, emphasis added)

Finally, this HRSDC-sponsored project entailed the use and development of indexes for scoring and ranking localized spaces (in this case EAs) relative to one another and according

to pre-defined criteria. The North York Community Mapping study produced three separate indexes for an assessment of space and place according to the imperatives of "optimal childhood development" and the "promotion of population health": The Early Development Index (EDI), the Social Risk Index (SRI), and the Physical Environment Scale.

Both the EDI and the SRI continue to be used in public policy and social services-provision milieu. In constructing the SRI the authors of the North York Community Mapping study selected nine variables "for their usefulness in describing the socio-economic characteristics of communities, encompassing measures in the areas of education, employment, poverty and multiculturalism" (Connor, Norris, & McLean, 2001, p. 63). The shading on the map (see Figure 4.2, above) classifies the EAs/neighbourhoods of North York according to four categories: those having "2 or fewer; 3 or 4; 5 or 6; 7 or more" of the nine identified "risks." For its part, the EDI "assesses children's development in five domains: physical health and wellbeing, social competence, emotional maturity, language and cognitive development, and communication skills and general knowledge" (Connor, Norris, & McLean, 2001, p. 2). The EDI and SRI are used by Canadian Mothercraft, a charitable organization "that serves children ages 0 to 6, their families, their communities and their teachers." The organization traces its roots to early 20th century public health efforts to reduce infant mortality rates in New Zealand by educating women in the "twelve essentials" for "raising healthy infants." The idea, which subsequently spread through the British Empire, was to "build healthy babies, rather than patch sick ones" (Bryder, 2001). Today, Mothercraft Toronto produces periodic reports based on SRI and EDI measures, and is also a key audience for and partner with, Wellbeing Toronto.

The EDI and SRI represent a further refinement, or "homing in" on particular risk groups. As we saw previously, Lalonde defined "youth" as a risk group for lung cancer and

cardiopulmonary disease, based on the understanding that the kind of behaviour patterns which lead adults to be "at risk" of morbidity and premature mortality from these causes are in fact formed in a much earlier period of the lifecycle. To adopt policies intervening in these risk behaviours only in the adult years would be to miss a crucial governmental and health promotion opportunity.

By the time of the publication of the Second Report on the Health of Canadians, the three most important risk groups had been identified as children, youth and Aboriginals (FPTAC on Population Health, 1999). The goal in a mapping study such as this one was thus to move from the "discovery" that all children aged 0-6 are "potentially" at risk, to the production of knowledge identifying the geographical location of communities where children were deemed to be "actually" at risk.

3.2 Standardized Neighbourhoods, Official Visibilities

In the community mapping study, which was commissioned before North York was amalgamated into the City of Toronto, "neighbourhoods" were understood as synonymous with census enumeration areas. In the post-amalgamation City of Toronto, neighbourhood boundaries correspond to those of Statistics Canada's census tracts, but they also attempted to combine historical and subjective elements in the designation and naming of these units, which are the level at which much social research and planning takes place. The constitution of these neighbourhoods is therefore significant in terms of understanding how the city and its "populations" are known and represented by official institutions, including municipal government, hospitals, philanthropic organizations and the media.

As previously noted, Toronto today has exactly 140 discrete, contiguous, official neighbourhoods for planning and social development purposes (see Figure 4.3, below). The division of the space of the city into these neighbourhoods is a phenomenon that dates to

the mid-1990s and has not changed since that time (I #12, personal communication, July 31, 2015).[13] These neighbourhood boundaries were "developed by SDFA [Social Development, Finance and Administration Division] and based on standard Census geography… as a geography for service planning purposes as opposed to being based on historic neighbourhood identity" (I #12, personal communication, July 31, 2015). This administrative geography has "since been adopted by the City of Toronto, multiple agencies and organizations for reporting on social wellbeing" (Toronto, 2014).[14] Neighbourhoods thus displaced planning districts as the primary geography for planning and development purposes in the period since amalgamation in the late 1990s (I #12, personal communication, July 31, 2015).

Following this, neighbourhoods took on a new dimension: now, in addition to being subjective and experiential geographies, they were also standardized and ostensibly objective political geographies. As a city official explained:

> there are no official historical boundaries for any neighbourhoods in Toronto. There were cities and municipalities and boroughs. If you look at old neighbourhood maps, they were points on the map. So there was a point that said 'Hoggs Hollow' and there was no boundary because nobody really knew where the boundary was. (I #12, personal communication, July 31, 2015)

Thus the idea of a neighbourhood as something with a discrete and objective boundary was something that had to be created. In the past, people knew where the municipal boundaries were, as legal and objective entities. Neighbourhoods were unbounded, fluid, and subjective.

The introduction of these administrative boundaries roughly coincided with amalgamation, which saw the new City of Toronto become incorporated on January 1, 1998.

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[13] According to this interviewee, "It is the intent to keep these boundaries consistent over time and as of 2014, they have not changed since their inception." (I 12, personal communication, July 31, 2015)

[14] Toronto Social Development, Finance & Administration. (March 2014). TSNS 2020 equity index: Methodological documentation. Retrieved from http://www.toronto.ca/legdocs/mmis/2014/cd/bgrd/backgroundfile-67350.pdf

Prior to amalgamation there were seven separate municipalities that comprised the regional municipality of Metro Toronto and six constitutive municipalities: Etobicoke, York, North York, the former City of Toronto, East York, and Scarborough. The 1998 amalgamation was the most recent of a long series of annexations and mergers that produced Toronto and its now constitutive municipalities, thus the above reference to "cities municipalities and boroughs" as the salient boundaries.[15]

With the amalgamation in 1998 Toronto became a single-tier municipality.[16] Prior to amalgamation, seven municipalities had their own planning offices and official plans to be carried out in accordance with separate land-use policies and administrative geographies. The bringing together of previously separate entities generated administrative problems (Boudreau, Keil, & Young, 2009 p. 99-100) to which the neighbourhood unit provided an answer. The local administrative entity emerged as the focal point of planning and development in the new City of Toronto. In the old City of Toronto, the comparable administrative unit was the planning district (Whitzman, 2009). This unit was not a neighbourhood-level administrative form, but a larger spatial unit. The neighbourhood scale was not "new" in an absolute sense, but it came to take on a different governmental significance into the early 21st century. As political scientist Martin Horak argues, "during the early years after amalgamation neighbourhood regeneration was very much off the citywide policy agenda in Toronto" (2010, p. 10) for several reasons, including "fiscal crisis" and the administrative chaos created by amalgamation (pp. 5-6). However, by 2005 "neighbourhood

[15] For example, the lands which now encompass the neighbourhoods of Roncesvalles and South Parkdale became a part of Toronto in the late 19th century when the villages of Brockton and Parkdale where annexed to the city in 1884 and 1889, respectively.

[16] Surrounding municipalities continue to be organized on two tiers with municipal and regional levels of government.

regeneration" had "emerged as a significant political agenda item in Toronto" (p. 6). Furthermore,

> within the City's administration the Social Policy Research and Analysis unit (SPAR) was, in the words of one informant, 'quietly working away' to develop a spatial perspective on poverty by devising the social planning neighbourhoods, and developing a statistical database on neighbourhood-level social indicators. (Horak, 2010, p. 10)

The rationale for introducing the neighbourhood as a bounded administrative unit was explained by a municipal official who was interviewed by the author for this project (I #12, personal communication, July 31, 2015): "for scientific reasons we needed something that has a lot of data," and so choosing something that would conform to "Statistics Canada geographies, which had been standardized over decades" was the best option, "because they just provide so much good data." In answer to the question of why neighbourhoods were chosen specifically, the respondent explained:

> Why do we choose neighbourhoods? It's the only geography that stays consistent over time…. What we found in the past was that people who relied on wards were sorely disappointed when the ward boundaries changed. And ward boundaries are very political…. Smaller levels of geography… like census tracts [CTs] or disseminations were also somewhat problematic. CTs are fairly consistent over time. They get split but the outer boundary stays the same so you can examine them over longer periods of time. The only problem is that *most people don't even know what a CT is*… it's a technical term for researchers and analysts and people don't really associate their area with a census tract, *like nobody says 'my census tract is 720.11'*…. People think of their area as a neighbourhood or a community maybe, right? (I12, personal communication, July 31, 2015, emphasis added)

Neighbourhoods are therefore the scale at which the city produces social data and programs for two reasons: first, to maintain consistency over time and with other more "data rich" levels of government; and second, echoing the point made by Goodchild (op cit. p. 173), because it is a scale that people can relate to and subjectively identify with. In other words, there should not be specialist geographies and lay geographies; the geographies of experts should be what ordinary people can relate to. This points to an important tension between

the two statements quoted above. On the one hand, neighbourhoods are described as things without boundaries: "nobody knew where the boundary was." But, on the other hand, neighbourhoods are idealized as "consistent" and stable geographies. The attribution of stability to neighbourhoods presupposes the superimposition of the neighbourhood map onto the census map. Neighbourhood boundaries are based on census tract boundaries (Toronto, 2016). It is in this specific sense that it is possible to claim that neighbourhoods, as bounded entities tied to knowledge production and governance, are "not political." They are not political because they are not subject to influence and wrangling of city councilors in the same was as ward boundaries are (I #12, personal communication, July 31, 2015). Neighbourhoods therefore provide a mechanism through which the abstract geography of census data can be absorbed in a meaningful way into people's everyday experiences.

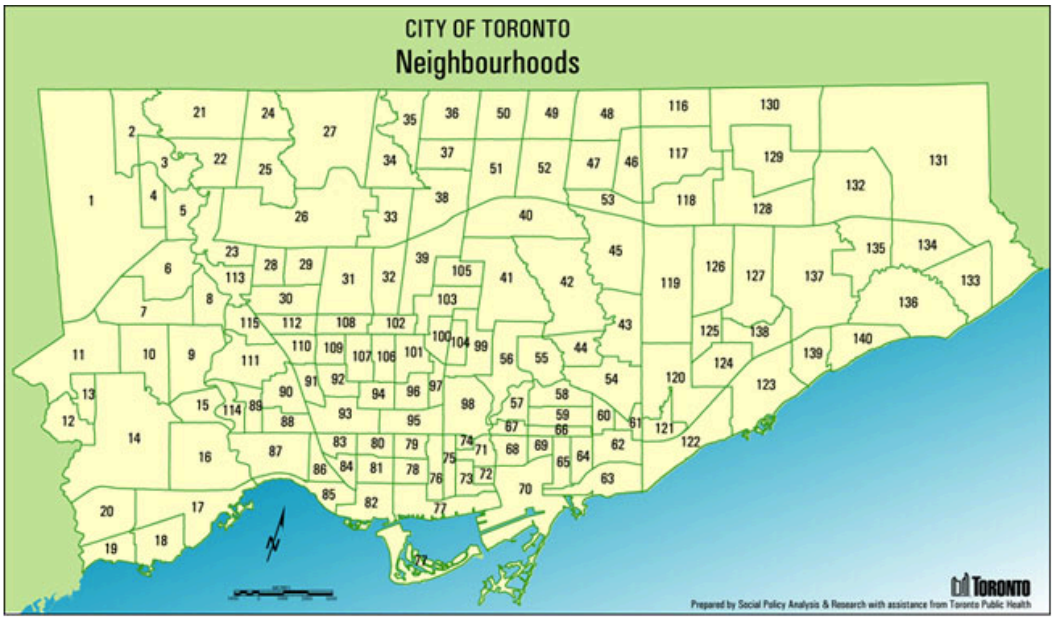

Figure 4.3: Standardized neighbourhoods, discrete, contiguous. (Source: City of Toronto, 2011. Reproduced with permission)[17]

[17] Compare with the increasingly ubiquitous Ork Maps version of Toronto released in 2012 (Blog TO Litwinenko, 2010): http://www.orkposters.com/toronto.html According to their website Chicago-based Ork maps has been making "original typographic city neighborhood maps, as beautiful as ever since 2007" (http://www.orkposters.com).

However, in at least three respects this expert knowledge-geography *is* political: first, it permits governance and resources to be allocated in particular ways, and according to particular kinds of priorities; second, it encourages local groups to align their administrative and organizational activities with broader governmental aims; and third, it treats the lived experience as static and capable of reflecting and conforming to the abstract geography. Thus it is deeply political in its very attempt to shroud "the local" from the messy business of experience and conflict that cannot be contained by these boundaries or by the presumed primacy of a particular "scale" of politics and economics.

In standardizing these neighbourhoods, the city undertook research to understand the historical boundaries of neighbourhoods, consulting with historians, old neighborhood maps (of which there are "surprisingly few" (I #12, personal communication, July 31, 2015), and published works such as David Dunkleman's *Guide to Toronto's Neighbourhoods* – which, incidentally has a heavy bias towards illuminating the shifting sands of the Toronto real estate market (Dunkelman, 1997, 1999, 2002). However, as my informant explained, this was an imperfect exercise—"like nailing Jell-O to a wall"—since historically, neighbourhood boundaries were fluid and subject to opinion and experience (I #12, personal communication, July 31, 2015). Thus, while the expert knowledge is attempting to align in some measure with experiential characteristics, the above speaker also notes that this is not always possible.

Neighbourhoods are not static entities, impervious to the dynamics of the lived realities of people and communities, and this is evident in public wrangling's over the rigidness of the boundaries used in the interactive web application Wellbeing Toronto.[18] This

[18] There were more than 30 external and internal "partnerships and collaborations," including with Citizenship and Immigration Canada, the Toronto District School Board, the United Way, St. Christopher House, City Departments of Transportation, Parks Recreation and Forestry, and academic experts from York University,

interactive social data and ranking tool received publicity through the *Toronto Life* ranking exercise discussed at the outset of this chapter (pp. 150-151). The informant said: "the Toronto Star thought our neighbourhoods were a little too rigid and a little too scientific-y and so they did a crowd sourcing exercise…. And they came up with something like 480 different neighbourhoods and they all overlapped" (I #12, personal communication, July 31, 2015).

The designation of what exactly a neighbourhood is, is thus highly variable and changes according to time and subjective experience, among other things. Nevertheless—or perhaps precisely because—"everyone has an idea of where the neighbourhood ends and it's all different", the policy imperative of standardized geographies remains: "we're not historians here, we're researchers. We try to look to the future, predict various trends, and help plan the city's growth and infrastructure and help with social problems" (I #12, personal communication, July 31, 2015). Thus, we see the governmental purpose of mapping, and the alignment of maps to questions of how to produce wealth, security, and a robust and orderly population. Administrative neighbourhoods are therefore conditions of possibility for certain kinds of visibilities and applications of data to defining and addressing social problems and opportunities.

3.3 Mothercraft: Mapping Early Childhood Development as Risk

The Canadian Mothercraft Society was founded in Toronto in 1931 by New Zealand-born nurse and midwife Barbara Mackenzie (Mothercraft, 2016). The Mothercraft Society originated in the New Zealand Society for the Health of Women and Children, "popularly known as the Plunket Society," so named after the wife of a New Zealand Governor and patron of the organization (Bryder, 2001). The Plunket Society was (and remains) a voluntary

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Ryerson University, McMaster University, and the University of Toronto (Wellbeing Toronto, personal communication, [August, 2015]).

organization which receives a substantial portion of its funding from the New Zealand government (Bryder, 2001). In 1917 Truby King, a British-born medical doctor and immigrant to New Zealand, founded the Society. King's famous mantra was to "build healthy babies instead of patching sick ones" (Mothercraft, 2016). To this end he preached the importance of educating young women, as eventual mothers, in the scientific principles of infant care, of which he claimed there were 12.

As an organization, Plunket was explicitly concerned with the health and vigour of infants in nationalist, pro-natalist, and eugenic terms:

> Plunket was founded and developed at a time when the promotion of health was urged for the sake of the preservation of the British Empire. The slogan of Plunket's 1917 'Save the Babies Week' – 'the Race marches forward on the feet of Little Children' – was revealing, as was the frequent claim that babies were 'our best immigrants.' (Bryder, 2001, p. 66)

By the post-WWI period Plunket was credited with giving New Zealand the lowest known child mortality rates in the world. Consequently, by the mid-1920's the Mothercraft Movement had "spread to all corners of the empire including: India, Jamaica, Scotland, Australia, South Africa, England and of course New Zealand where it all started" (Mothercraft, 2016).

In the early days of its Canadian iteration, the Mothercraft Society (as it is called here) was focused on infant care; however, this eventually grew to include an emphasis on early childhood care as well. Up until the 1960s, Mothercraft centres were primarily places where women could take their babies, and later toddlers, to receive advice about matters such as nutrition and sleep regimens. Up until that time, Mothercraft also provided direct care only to infants awaiting adoption. However, from the 1960s onward Mothercraft gradually expanded its range of interests and services geared towards the "building of better babies": in 1965 it opened the first infant childcare center in Toronto, and in the 1960s it

also took a growing interest in research on matters related to childhood development, care, and the effects of socio-economic deprivation.

Today the Mothercraft organization consists of three main branches of activity, all of which are focused on the advancement of early human development and the brain-centred neuro-logic (Chödrön, 2015) of producing "quality human beings": (1) early childcare and education and intervention programing; (2) the training and education of future early child education workers; and (3) the production, maintenance, and dissemination of scientific evidence and data pertaining to early human development.

As of 2016, Mothercraft operates one Ontario Early Years Centre (OEYC) with six satellite locations. OEYCs are provincially funded centres that offer free human development-oriented, drop-in programing for children 0-6years old and their parents or caregivers. Mothercraft also maintains a network of fee-for-service childcare centres for infants, toddlers, and pre-school-aged children. In addition to these early learning and care activities the organization also offers a series of "early intervention programs." The latter programs are described as "unique service collaborations, comprehensive programs, and flexible and responsive approaches" aimed at delivering "interventions to support young children with established special needs and their families, or those whose development may be at risk due to biologic and psychosocial risk conditions including parental substance use problems and related issues, such as domestic violence and mental health problems" (Mothercraft, 2016). The organization also maintains a registered "highly specialized" private career college, called the Mothercraft College, which offers Early Childhood Education diplomas. Their diplomas are "recognized by Ontario's College of Early Childhood Educators (CECE)" (Mothercraft, 2016).

In Toronto, the Mothercraft organization is a key milieu through which spatialized knowledge about risk and early childhood development is collected and circulated. Mothercraft is tasked with the collection, aggregation, and publication of EDI data, gathered in the Toronto District School Board. This data is collected and published every 3-4 years, in conjunction with the SRI (social risk index), in map form, and broken down according to the city's 140 official neighbourhoods (see Table 3, below). This allows the organization to classify each official neighbourhood into one of three categories: (1) neighbourhoods with low social risk and high EDI (optimal); (2) neighbourhoods of high social risk and low EDI (sub-optimal); and (3) neighbourhoods where levels of risk and EDI outcomes do not conform to expectations (neighbourhoods of interest) (see Figure 4.4, below).

In 2011 Mothercraft produced a series of maps of the city of Toronto that showed all neighbourhoods according to their EDI scores, thus presenting a visual narrative describing the places in the city where "optimal humans" are being produced, and those neighbourhoods where development outcomes are understood to be "suboptimal" (Murray, 2015, p. 282).[19] Figure 4.4 shows one such map, which highlights the federal/provincial riding of Parkdale-High Park and the seven city neighbourhoods that fall within or partially within its boundaries.[20] The map shows neighbourhoods according to the percentage of children who received low scores on each of the five EDI categories. Neighbourhoods which had a high percentage of low-scoring children in none of the categories or only one category are shaded the lightest. These constitute the majority of the city's neighbourhoods. Neighbourhoods with a high percentage of low-scoring children in 2-3 domains are shaded

[19] This refers to the third such series, after 2005 and 2008. See Mothercraft. *Riding profiles*. Retrieved from http://www.mothercraft.ca/index.php?q=current-and-past-results

[20] Riding boundaries as per Statistics Canada, 1996. Six neighbourhoods fall within the boundaries: 85-89 and 114; the seventh, neighbourhood 90, or Junction Area, falls partially within the 1996 boundaries (Mothercraft, 2011).

somewhat darker; and those with high percentages of low-scoring children in 4-5 domains are shaded darker still. Notably, the majority of such neighbourhoods are concentrated in the North West of the City in the former Borough of North York.

The map further identifies what it refers to as "neighbourhoods of interest," which are defined as those neighbourhoods that "produce unexpected EDI results" (e.g. a neighborhood exhibiting a number of risk characteristics related to poor child development, yet has relatively few children scoring low on any of the EDI domains)" (Mothercraft, 2011). In the highlighted area of Parkdale-High Park, two of the seven neighbourhoods stand out as "abnormal": South Parkdale (#85), for its high number of low-scoring children; and Roncesvalles (#86) for its "unexpectedly" low rate of low-scoring children, given its relatively high SRI score (Mothercraft, 2011). This is one of a myriad and growing number of ways that the "outcomes" of local communities are mapped, indexed, and ranked by governments, university researchers, and not-for-profit sector organizations, at times in collaboration and often drawing on similar or related data sets.

The map (and others like it produced in previous years, see Table 4.1) brings South Parkdale and Roncesvalles into visibility as different from the other neighbourhoods in the riding, as well as the majority of neighbourhoods across the city that are depicted as having low social risk and high EDI. Parkdale, the southern-most neighbourhood in the Parkdale-High Park riding and shaded in the darkest gradation, is ranked as both a "high risk" neighbourhood, and low-scoring EDI neighbourhood: "South Parkdale has the highest percentage of children identified as having multiple challenges in this riding" (Mothercraft, 2011). Roncesvalles, by contrast, is marked as a "neighbourhood of interest" since it has both high risk and high EDI scoring. Roncesvalles is "of interest" because it does not

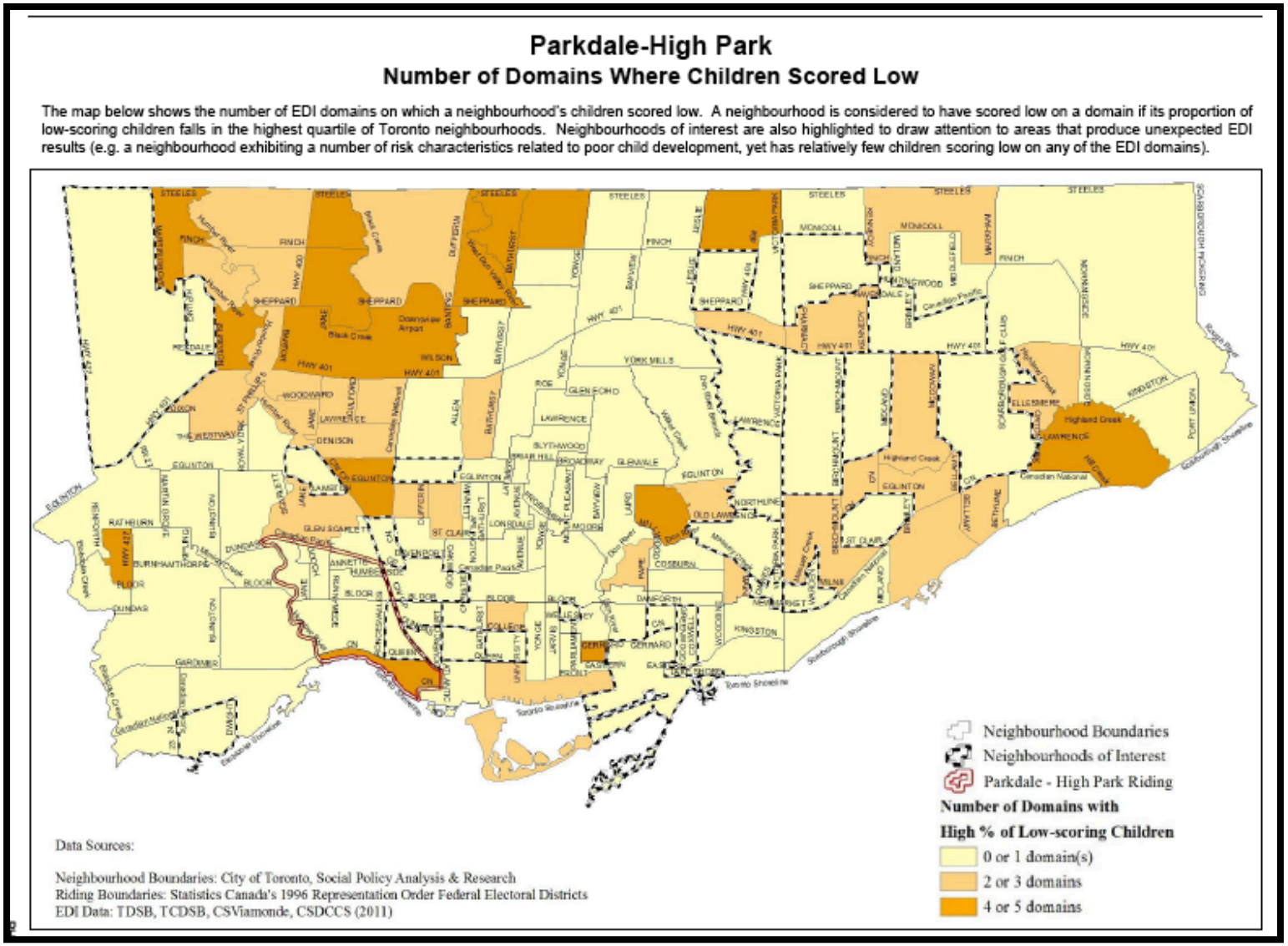

Figure 4.4: "Number of Domains Where Children Scored Low" (Source: Mothercraft, 2011. Reproduced with permission).

conform to the organization's stated expectation of a correlation between high "social risk" and sub-optimal "human development": "When a neighbourhood is considered to be high risk (as indicated by the Social Risk Index) the general expectation is that the children residing in that neighbourhood will exhibit lower EDI scores. Roncesvalles was found to be a high-risk neighborhood, however, contrary to expectations, it has relatively fewer low-scoring children than other neighbourhoods" (Mothercraft, 2011).

3.4 Wellbeing Toronto: From Expert Measures to Popular Sensibilities

Launched officially and with little fanfare on July 30, 2011 (I# 12, personal communication, August 31, 2015) by the City of Toronto's Department of Social Development, Wellbeing Toronto is the cutting edge of data visualization and social services planning in Toronto. It represents a culmination of the newly ascendant and legitimized focus on identifying "priority neighbourhood areas for investment" (PNIs, or more commonly "priority neighbourhoods") as a way to address "historic underinvestment in the community infrastructure in some Toronto neighbourhoods [that] had resulted in a variety of challenges particularly in the area of community safety and particularly for racialized youth" (City of Toronto, 2014, p. 3). It was one of many strategies pursued by the city "to improve the quality of life for residents and enhance Toronto's reputation as a world class city" and to "increase community resilience to emergency situations" (2014, p. 3). Wellbeing Toronto is an open data project which "leverages" and consolidates data from across the municipal corporation and makes it available to individuals, organizations in the for-profit and not-for profit sectors, and government bureaucracies. It was developed and continues to be used and maintained in partnership with a range of agencies and organizations (39 in number) both inside and outside of the municipal corporation. These partners include the housing department; the Department of Parks, Forestry and Recreation, the Department of Social

Development and Finance, as well as external partners such as Citizenship and Immigration Canada, the Toronto District School Board, Local Health Integration Networks (LHINs), the Wellesley Institute for Urban Health, the Centre for Inner City Health Research at St. Michaels Hospital, and academic experts from the University of Toronto, York University, Ryerson University, and McMaster University (City of Toronto, SPAR, n.d.).

The City of Toronto launched its Wellbeing Toronto application as part of its open data strategy. Arising from broader initiatives towards "transparency" and "community empowerment," Wellbeing Toronto is a data processing application that makes it possible for anyone with an Internet connection to "better understand the diversity of Toronto's neighbourhoods (City of Toronto, 2016).[21] Originally named "Neighbourhood Wellbeing Indices," Wellbeing Toronto brings together data from "several City Divisions, Statistics Canada, Agencies, Boards and Commissions and other Non-government organizations" (Toronto, May 2015). The data are used to create indicators in 11 broad fields, each of which is comprised of a number of sub-indices: demographics, civics and equity, economics, education, environment, health, housing, recreation, safety, transportation, and culture (City of Toronto, 2016).

The immediate impetus to develop a wellbeing index emerged out of the perceived need to update the city's first *Strong Neighbourhoods Taskforce* report (2005), produced in partnership with the United Way and published in 2005. The *Strong Neighbourhoods* report identified 13 "priority neighbourhoods," based on a "custom GIS analysis… to identify service gaps and priority, needy neighbourhoods" (I #12, personal communication, July 31, 2015). Once these neighbourhoods were identified, this information was then "leveraged at

[21] City of Toronto. *Wellbeing Toronto*. Retrieved from http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=4209f40f9aae0410VgnVCM10000071d60f89RCRD

the political level to get over a hundred and twenty-five million dollars of funding from the City, the province, the federal government and other organizations… to invest more in these neighbourhoods" (I #12, personal communication, July 31, 2015).

In 2008-2009, when the question of updating the priority neighbourhoods analysis in light of new developments and new data came up, a committee called the "Staff Reference Group on Neighbourhood Wellbeing Index and Community Partnership Strategy" was formed. This committee responded to input from different divisions at the city, and recommended to Social Development [i.e. Social Development, Finance & Administration] that, rather than producing a new "custom analysis for this particular problem [of service gaps and needy neighbourhoods] we create a tool that would allow other divisions and other organizations to customize the type of layers, research and analysis that they wanted to do for their specific needs" (I #12, personal communication, July 31, 2015). Initially, the idea was to develop indexes for all of the city's major domains of governance: "a transportation domain, a housing domain, a recreation domain, that kind of thing." This production of "sub-indexes" could then be rolled up into a grand index, capable of producing a single rank for all of the Cities 140 neighbourhoods (I #12, personal communication, July 31, 2015).

Indeed, the tool and the data it makes available are used by a broad range of actors including not-for profit organizations, other levels of government, and individual citizens. When I asked a municipal official if any organizations stood out, the informant named Mothercraft as an especially important user. However, the informant also stated that the tool was broadly useful in making particular places and people who need "investing in" visible to a broad range of actors who might not otherwise be aware of the community in which they invest:

> You go here and you click this indicator for this demographic group and this income level and [whatever other indicator(s)], and you get your top three or top five

> neighbourhoods that you can invest in. That's essentially what a lot of NGOs are using it for. They often have limited funds. They get a grant of 10,000 dollars or 50,000 dollars and they're told, "Help some people." Help, I don't know, Sri Lankan youth. And they try to call up people and say, "Well, where do I find Sri Lankan youth," right? Well, that's easy. You go to Wellbeing Toronto, click on Ethnicity: Sri Lankan. Then you click on Age Group: 15-24. You overlay those two things. You click another button. You get your top three, or top one if you've only got 5,000 dollars, and you've got your one neighbourhood and that's the neighbourhood you should be investing in. So that's the idea. (I #12, personal communication, August [date?], 2015)

Eight months after its launch the city did a follow-up survey to see who was using the application and what they liked about it:

> We were surprised to find… the plurality of users were the average person, citizens who were not affiliated with an organization. Second-largest were government staff of various kinds, multiple levels of government, because we had… tried to reach out to our contacts in government. And the third were students…. So there were a lot of people who we didn't expect initially to be using it who started using it. (I #12, personal communication, July 31, 2015)

Despite the fact that the launch of the platform was not advertised it receives "four times more traffic than we got with the old demographics page… like PDF reports and things like that…. We have four times as much traffic to Wellbeing Toronto as we used to have to the old paper stuff" (I #12, personal communication, July 31, 2015). The broad use of the platform is seen in terms of the success of the objective of "opening the black box" of government policy and data. Now, people can use it for whatever they wish, and it saves city staff a great deal of time in answering the public's questions about "basic information" and "basic data":

> There were people who were calling from overseas, expats, who were coming to Toronto. People who were moving from other parts of Canada. They wanted to find a nice neighbourhood to live in, right? So they wanted basic info like that. People who were starting businesses. We had one woman who was starting a yoga studio and she wanted to find the perfect neighbourhood to do it in. She wanted a certain demographic and she wanted a certain income level, etc., and so she wanted all these kind of basic stats and I said, "Well, this is exactly what you need to do it. You go here and you click this indicator for this demographic group and this income level and this whatever, and you get your top three or top five neighbourhoods that you can invest in." (I #12, personal communication, July 31, 2015)

In this way the scientific power to rank neighbourhoods in terms of where best to "invest in" goes all the way down to the individual level of buying a home or starting a business in a neighbourhood that has the "right demographic mix" for your particular enterprise. In this example, specifically, we can see multiple layers of the ways in which the platform facilitates the mutual production of health and local space, as well as the multiple connections between health and the production of value: on the one hand, people want to find a neighbourhood that corresponds to their understanding of "wellbeing" where they can rent or purchase a home, and on the other, it helps a woman who wants to open a yoga studio determine where the most profitable place to do so is likely to be located.

Wellbeing Toronto seeks to push the boundaries of mapping as a tool for social policy development, in line with the spirit of "open data" by allowing users to "define their own risks" in seeking to determine the "best" and "worst" places for them to "live, work shop and play" (Wright, 2010) in Toronto. As such, it frames the role of information in a democratic society in terms of the imperative to "open the black box" of data. Implicitly, what it does not challenge is the self-evident "goodness" or value of ranking, indexing, and benchmarking human beings and their "communities" emerging out of trends in population health and health promotion research.

In fact, Wellbeing Toronto gained increased attention in 2013 (D'Cruz et al.) when the Martin Prosperity Institute partnered with *Toronto Life* magazine to produce an elaborate "spin-off" neighbourhood-by-neighborhood ranking, which drew heavily from data made newly available through the online open data tool, as well as more conventional sites such as Statistics Canada. Founded in 2007 in honour of creative class guru and "relocation agent of the global bourgeoise," Richard Florida (Whyte, 2009, citing Uzma Shakir), the Martin Prosperity Institute is a think tank based out of the University of Toronto's Rotman School

of Management. The institute is devoted to exploring "the necessary requirements to achieve a prosperous future for all – one in which democracy and capitalism work in support of each other" (Martin Prosperity, 2016). *Toronto Life* is a popular upper-middle-class lifestyle magazine that aims to help its readers make "smart choices about everything from restaurants and shopping to real estate and culture" (*Toronto Life*, 2016). Published in the Real Estate section of the magazine, it seems clear that a major purpose of weighing into the ostensibly "timeless" debate over what neighbourhood is best is aimed at actual and prospective homebuyers in particular.

The Martin Prosperity Institute ranking included both an "overall" ranking of neighbourhoods and a series of rankings by category (transit, housing, etc.). To do this, the Institute drew on a wide range of data from governmental and non-governmental sources, such as Statistics Canada and data made available through Wellbeing Toronto:

> On August 14, 2013 Toronto Life released their August issue which included a ranking of Toronto's neighbourhoods, found in: *The Best Places to Live in the City: A (Mostly) Scientific Ranking of All 140 Neighbourhoods in Toronto*. The article presented an overall score for each neighbourhood within the City and ranked them accordingly, while providing a detailed scorecard for each neighbourhood. The Martin Prosperity Institute contributed to this article by collecting the data and defining the methodology for scoring and ranking the neighbourhoods. Data was gathered from a variety of sources including Statistics Canada, City of Toronto statistical research, Toronto Police Service, the Centre for Research on Inner City Health [CRICH] and the Fraser Institute. As expected, the neighbourhood rankings generated discussion throughout the city in regards to the results. (Martin Prosperity Institute, n.d.)

The method for this exercise in "ranking" produced for *Toronto Life* is explained as follows:

> In order to produce an overall ranking for each neighbourhood, we compiled data… which are representative indicators in the ten categories of Housing, Crime, Transit, Shopping, Health and Environment, Entertainment, Community Engagement, Diversity, Schools and Employment. Each neighbourhood's individual score for each of the ten categories is available as a score out of 100. The score was assigned based on the *maximum performance* among all neighbourhoods so the score represents the percentile of that neighbourhood in comparison to the rest of the city. When more than one indicator was used within each of the ten categories, the percentiles were equally weighted and the average was used as the category score. (Martin Prosperity Institute, n.d., emphasis added)

Wellbeing Toronto is therefore interesting for the ways it is connected to, and the ways it enables, other mapping, ranking, and benchmarking initiatives, as well as for its unique nature as an interactive, neighbourhood mapping tool, which "allows and empowers citizens to define their own 'at risk' communities themselves within a transparent application based on their own criteria" (City of Toronto, 2016).[22] As such, it is an example of the cutting edge of new techniques of governance bound up with the co-production of place, local space, and health.

There is a connection between the increasing discursive emphasis on "neighbourhoods and communities" coming out of the "Health for All" and "Healthy Cities Movements," and the growing emphasis on mapping as a mode of abstracting and communicating demographic and health-related information about people and places. While Wellbeing Toronto is not a GIS application, the normalization of this mode of knowing is nevertheless related to the development and growing commercial availability of GIS technology and the increasingly detailed and "granular" information that this technology makes it possible to produce and present. There are limits, both physical and virtual, to "pages" which render the abstraction and reproduction of the social attributes of space at small scales simply impractical. The "local" appears increasingly as a logical application and outgrowth of massive data-generating capacity, and the ontological limits of how this can be represented. But this raises serious questions about how both specialist and "common sense" understandings of social space are defined and acted upon. Are the "healthy" and "unhealthy" neighbourhoods discrete socio-spatial entities? Or are they fundamentally relational, produced through processes that span entire cities, city regions, or the "global"?

[22] City of Toronto. *About Wellbeing Toronto*. Retrieved from http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=454b186e20ee0410VgnVCM10000071d60f89RCRD&vgnextchannel=4209f40f9aae0410VgnVCM10000071d60f89RCRD

The logic of indexing emerges in tandem with this, as the logical extension of the need to produce "as precise as possible" knowledge about populations and risks, such that they can be effectively and efficiently "targeted" in an age of austerity.

In 2001 when the *Vancouver Sun* published a map of neighbourhoods' "school readiness," based on the EDI and correlated to poverty status, such an image was both novel and provocative. Today, such maps are increasingly ubiquitous. Not only are they periodically made available to the public in the form of on-line reports and news media coverage of population health-inspired neighbourhood mapping exercises (i.e. Boyle, 2014; *Toronto Life*, etc.). The advent of Wellbeing Toronto now means that similar maps about the City of Toronto can also, in theory, be produced by anyone with an Internet connection. Thus, a broad range of users can generate visual information in the form of charts, graphs, and maps, pertaining to a wide array of data sets that are understood to be connected to "wellbeing." As the city's open data website states to prospective users: "Not sure how to use Open Data? Don't have the technical skills? Check out Wellbeing Toronto where you can use all kinds of data in many ways" (City of Toronto, 2017a).

3.5 Urban HEART@Toronto

The launch of Wellbeing Toronto in 2011 did not signal the end of expert-driven measures to select specific neighbourhoods for immediate targeted investment. In 2014 the city announced a new "equity score" developed in partnership with the Urban HEART@Toronto initiative, based out of the Centre for Urban Health Solutions (C-UHS), formerly the Centre for Research on Inner City Health (CRICH),[23] at St. Michael's Hospital.

[23] The name change took effect June 1, 2016 to reflect the increasingly well publicized fact that "poverty increasingly affects people living across our cities, not only those people in the downtown cores" (Hwang, 2016). See also, for example Hulchanski, 2010. With respect to the precise timing of the change, however, it is difficult not to wonder whether Donald Trump's controversial and polarizing rhetoric about US "inner cities"

St Michael's is a large teaching and research hospital affiliated with the University of Toronto and located in the downtown core near Yonge Street and Shutter Street. A Catholic hospital, it was founded in 1882 by the sisters of St. Joseph to "to care for the sick and poor of Toronto's inner city" (St. Michaels, 2016). This is a mandate which it continues to pursue to this day: "As downtown Toronto's adult trauma centre, the hospital is a hub for neurosurgery, complex cardiac and cardiovascular care, diabetes and osteoporosis care, minimally invasive surgery and care of the homeless and disadvantaged" (St. Michael's, 2016). The Centre for Urban Health Solutions has a comparatively recent history, having been established in 1998, roughly 100 years after the founding of St. Michael's. Working from a social determinants of health perspective, "the Centre is focused on developing, evaluating and scaling-up programs and policies" (St. Michael's, 2016).

The Urban HEART@Toronto tool is one such project. Urban HEART is an acronym that stands for Health Equity and Response Tool. Urban HEART is a research and policy program launched by the WHO in 2010 and originating in the WHO's healthy cities and communities initiative (St. Michael's C-UHS et al., 2017). It is designed as a ranking tool to produce scientific assessments of the overall state of inequities in urban environments of low- and medium-income countries, based on a social determinants of health model. It is characterized as a "simple," "practical" and "evidence based tool" that uses a three-category, colour-coded system to "shed light on where, why and how our diverse initiatives are/aren't converging well to produce real change" (St. Michael's, C-UHS et al., 2017). Based on 15 indicators in five broad categories[24], it designates neighbourhoods as green, meaning "equal to or above the target"; yellow, meaning "higher than the benchmark but below the target";

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also had something to do with the change. See http://www.stmichaelshospital.com/crich/impact-stories/our-new-name-centre-for-urban-health-solutions

[24] These five categories are economic opportunities, social and human development, governance and civic engagement, physical environment and infrastructure and population health (St. Michael's CRICH, n.d.).

or red, meaning "below the benchmark" (St. Michael's, CRICH, n.d. p. 5). "Green shows us where local conditions are positive, while yellow and red point to conditions that need a closer examination" (p. 3).

Urban HEART@Toronto is a made-in-Toronto adaptation of the tool, designed in consultation with "over 80 experts in 40 institutions" (St. Michael's C-UHS et al., 2017) to identify and address these inequities. And, while the executive summary report cautions that the red/yellow/green scheme should not be used as a form of ranking, but rather only as an indicator of "where to look more closely," in practice Urban HEART@Toronto has been used for precisely that. Beginning in 2012 the City of Toronto partnered with CRICH (as it was then called) to produce neighbourhood equity scores—effectively a form of ranking—for each of the city's 140 neighbourhoods. The results, announced in 2014, were then used to produce a benchmark to allow policy makers to identify those neighbourhoods falling below it. It is a "tool that grades every neighbourhood in the city on 15 measures of health and wellbeing: everything from education to voting rates, the number of healthy food stores and the rate of premature deaths" (Boyle, 2014).

In conjunction with the development of the equity score, the city shifted the language from "priority neighbourhoods" to "Neighbourhood Improvement Areas" (NIAs) in conformity with the language of Business Improvement Areas (BIAs). Thirty-one neighbourhoods were announced as falling below the benchmark and thus were designated as NIAs. Of these, 15 had previously been designated priority neighbourhoods. Eight of the 23 priority neighbourhoods designated in 2005 moved out of the "red zone," and 16 neighbourhoods were newly designated as requiring "immediate attention" (City of Toronto, 2014).

In its coverage of the launch of the equity score the *Toronto Star* went on to give a snapshot of what had been revealed as the "neediest" and also the "healthiest" neighbourhoods:

> Among the healthiest neighbourhoods are [sic] North Riverdale with no red-zone measures and 12 in the desirable green zone. Only 4.1 percent of households are on social assistance and 80 percent of adults have post-secondary credentials. Rosedale-Moore Park also has no red zone measures and 11 green. Only 2.4 per cent of tis households are on social assistance and 90 per cent of adults have post-secondary credentials. (Boyle, 2014)

Here we can see how easily the message that "poverty is bad for your health" becomes the message that "the presence of poverty" (and a myriad of proxies for it, such as education, voting behavior and the presence or absence of healthy food stores) "is bad for neighbourhood health."

4. Conclusions

This chapter examined the development of population health and the epigenetic field of human development, under the leadership of the Canadian Institute for Advanced Research. It further demonstrated how epigenetic norms are expressly or implicitly being adopted across very diverse fields of knowledge production—a popular magazine, a not-for-profit social services organization, a hospital-based research institute, and the city's Department of Social Planning and Finance. There are two key conditions of possibility for this: the advent of epigenetics; and the development of more powerful and sophisticated systems for storing, manipulating, and displaying geographic information. Here the population health critique brought early childhood and its social and physical environment to the foreground in public health thinking. The development and application of GIS mapping techniques to social research and social policy made it possible to visualize urban space in epigenetic terms, as population health and human development became tied to new ways of representing local

space through the application of GIS mapping techniques. At the turn of the millennium, the act of mapping social risk onto neighbourhoods ceased to be a metaphorical, narrative exercise, and became a visual, technical reality. Bound up with this shift is the production of an intimate spatiality: the ability to present risk as a real attribute of a specific and concretely delineated "neighbourhood," not just an "abstract" or "hypothetical" one. At the same time as the "precise" and "granular" qualities of space are rendered increasingly amenable to knowledge production, the space and time of body are opened up to a policy gaze in new ways. These processes happen in the name of freedom, efficiency, and improved health and wellbeing. But they are totalizing processes that aim towards bringing ever deeper and more intimate layers of the fabric of life under their purview.

Whereas in the post-War period "health" was a domain of knowledge tied to national-scale indicators such as morbidity and mortality, in the period since the 1970s this scale of knowledge and truth has been joined to the technical capacity to produce increasingly detailed knowledge about local space and its presumed relationship to health at much finer gradations than has been possible in the past. At the same time, the body itself has been opened up to new forms of knowledge in efforts to locate precisely the nexus of nature-nurture linkages, and thereby to be able to "carve nature at the joints." These shifts have tended to focus on childhood brain development as the pre-eminent time and space of health vulnerability. They also have sought to tie neurologically defined health "risks" to specific physical and especially social attributes of local spaces. The presumed benefit of this is to be able to devise ever more precisely targeted interventions to optimize the health of populations. This, in turn, has had the effect of redefining "equity" in terms of risks to health optimization and the capacity to mitigate disease susceptibility across a given population or populations. In contrast to the earlier logic of health as a good to be

redistributed in the service of the twin aims of human betterment and national economic growth, health is now tied to equity through a logic of risk mitigation, in the name of producing a thriving and globally competitive metropolitan economy. The quantification and assessment of equity as risk allows for targeted intervention in the name of health and in the service of this broader biopolitical objective.

Concomitant with this shift has been an effort to define and locate "risks" more precisely in time and space. Drawing on the science of epigenetics, this has led to the identification of early childhood as a key time for intervention, and a governmental apparatus for presuming to locate the risks to specific neighbourhoods with specific spatial attributes. However, this is a precision that is trained on groups, and not on individuals. Whereas Charles Hastings' enumeration of health conditions in early 20th century Toronto entailed recording the precise details of *specific* homes and residences, today the favoured unity of analysis is the neighbourhood. In contrast to the early 20th century, when the visibility of "slum" neighbourhoods as the location of the greatest contagion threats to the health of the city was paramount, today any and all neighbourhoods can and should be brought into visibility vis-à-vis social determinants of a health-informed model of urban governance. However, in bringing neighbourhoods into visibility with respect to one another in the forms of ranking and benchmarking, these modes do not merely describe hierarchy; they also produce different kinds of relationships across the city's "real" urban neighbourhoods, in ways which in turn shape how policy makers, service providers, and ordinary citizens imagine and relate to them.

Yet, despite the rhetoric of "health beyond health care" and the marked rescaling and respatialization of "risk," there are nonetheless a few key continuities that can be pointed to. First and foremost we see that the language of economics continues to supersede that of

justice for its own sake. We do not improve health and alleviate the suffering of poverty because it is a matter of justice in a democratic society. Rather, we do it in the name of the biopolitical imperative to optimize the health and longevity "of each and of all" (Foucault, 1982). Second, when the question of justice does arise, it is still in conjunction with the insurantial logic of risk management. Whereas Medicare is characterized by an insurantial logic that protects individuals against certain costs associated with the possibility of future illness and accident, equity benchmarking is a technique through which the city as such is secured, insured, and indemnified against what are presumed to be its place-bound risks.

By examining its conditions of possibility in trends linking local environments to health through the techniques of epidemiology and map-based socio-spatial analysis, we can more clearly see the specific technologies and rationalities through which "health" and "wellness" are articulated to local space and social environments for governing the living and managing social inequality. Finally, through an analysis these techniques we can more clearly see how the will to produce social facts about the relationship between health and environment replaces and displaces the analysis of social relations: as more and more facts are marshaled to illustrate that there are "persistent," "consistent," and growing gaps in income or health across the city, rarely if ever is it accompanied by attempts to explain how or why this might be the case.

Chapter 5
"It's Not a Polish Neighbourhood Anymore": Gentrification and the Vital Politics of Space in Parkdale[1]

> — "[Roncesvalles Village is] the most perfect corner of Toronto that we have left." (Aguirre-Livingston, cited by Bowker, 2011a)
>
> — "After a multiyear neighborhood reconstruction project that temporarily cut streetcar service and starved merchants, Roncesvalles Avenue — the area's main artery — is thrumming again. Despite their big-city location, the street's indie bookstores, quirky coffeehouses and smart boutiques feel more like small-town hangouts, with stroller-pushing locals popping in to chat up proprietors. Tree-lined and low-slung, with a blessed absence of the chain stores that have crept across Toronto, the rejuvenated "Roncy" now makes for one of the city's most engaging strolls." (Kaminer, 2012)
>
> — "While it's just a few kilometers (and an easy streetcar ride) from downtown Toronto, Roncesvalles retains a decidedly small-town feel. Polish immigrants settled here in the 1950s and 60s, and the influence of that community can be felt from the stately St. Casimir's church to the delis offering the city's best paczki doughnuts. Roncy's newer arrivals, including creative professionals and young families attracted by the neighbourhood's relatively affordable, handsome brick houses, have brought with them an array of destination eateries, artisanal ice cream shops and independent businesses selling made-in-Toronto clothing and accessories. Thanks to its easy walkability and community-minded residents, Roncy feels less like another Toronto district and more like a village within a city." (Freed, 2016, p. 7)

1. Introduction

The above quotes are taken from *The Grid*, a Toronto lifestyle weekly; the travel section of *The New York Times*; and Porter Airlines' in-flight magazine, *Re:Porter,* respectively. All three quotes describe the neighbourhood of Roncesvalles after the completion of a major reconstruction project that saw water and transit infrastructure replaced, accompanied by a major streetscape redesign and beautification project. This was made possible by funds from

[1] Anonymous Interview #6 (personal communication).

federal and municipal governments, the local business association, and other resources, such as volunteer labour mobilized by the business association.

These quotes suggest two key things. First that there is an "ideal" type of neighborhood. Second that Roncesvalles is a distinct neighbourhood that embodies this ideal. These passages reflect the kinds of "objective" ranking and benchmarking exercises introduced in the previous chapter. Against this backdrop, the central question of this chapter is: how did Roncesvalles emerge as the kind of idealized space depicted above? How should we understand the emphasis on a "small town atmosphere," "family friendliness," "tree-lined streets," and "walkability" within the broader dynamics of health in emerging forms of urban governance?

This chapter considers the role of discourses and practices pertaining to the "health" and "vitality" of bodies and spaces surfacing in spatial imaginaries and practices in Parkdale. I argue that a vital politics of space is a constitutive feature of the process of gentrification in Parkdale. This vital politics is particularly apparent in efforts to produce "Roncesvalles Village" as spatially distinct from Parkdale. The chapter builds on the previous discussion of the emergence of neighbourhoods as a particular political geography (Toronto, 2014, 2016; Wright, 2010), that contrasts to older understandings of neighbourhoods as experiential geographies. This political geography is an important condition of the possibility of producing distinction—that is, neighbourhoods understood as "great," the "best," or the "most perfect"—both in descriptive accounts and through scientific exercises of ranking and benchmarking.

The chapter focuses on the supposedly objective differences between South Parkdale and Roncesvalles in order to show how expert knowledge pertaining to health and wellbeing has brought neighbourhood spaces into visibility, relationally, over time. We will see how

distinction is produced through official ideas and definitions of "health", and in changing street-level practices. The analysis traces the emergence of the newly named Roncesvalles Village, as a perceived ideal and a material reality that has been strategically carved out of the space of Parkdale.

The chapter consists of four parts. First, I give a brief discussion of current literature on gentrification in Parkdale. Second, I provide a brief sketch of the history of Parkdale. The third and fourth sections give an account of how a politics of vitality is currently shaping a spatial politics of distinction in Parkdale. The third section provides a descriptive account of how the toponyms "Roncesvalles" and "Roncesvalles Village" emerged as strategies for setting Roncesvalles apart from Parkdale. I argue that this distinction is produced relationally, in that the desirability of Roncesvalles depends implicitly and explicitly on the undesirability of Parkdale. This process is not only racialized in the sense described by urban geographer Cheryl Teelucksingh (2002), it is also a healthified space in the sense described by public health scholar Carolyn Fusco (2006). The healthification (Fusco, 2006) of Roncesvalles depends on the nominally "sub-optimal" health of South Parkdale. The fourth and final section builds on this through a discussion of the role of the Roncesvalles Village Business Association in shaping infrastructure redevelopment and beautification in the area, and its relationship to ongoing efforts to brand the neighbourhood as a space of "clean, green" community activism and consumption.

2. Gentrification in Parkdale: The significance of "distinction"

While there is an existing literature on gentrification in Parkdale, there is no corresponding literature for Roncesvalles, also known as "Roncy," the hip shorthand name for the area used by the publications cited in the epigraph to this chapter. This is at least partly due to the fact that the emergence of Roncesvalles as separate from Parkdale, is a relatively recent phenomenon. South Parkdale and Roncesvalles are two of the City of Toronto's 140 official local administrative districts, designated as neighbourhoods numbers 85 and 86, respectively. In the past, these two neighbourhoods were understood as comprising the north and south parts of Parkdale (Teelucksingh, 2002; Whitzman, 2009). Both areas overlap with the 19th century boundaries of the Village of Parkdale (see Map 5.1, below), though the northern end of official Roncesvalles would have fallen within the boundaries of 19th century Brockton Village (today's Little Portugal, or administrative unit number 84). Today, however, Roncesvalles and South Parkdale are treated as two distinct spaces in both in the mainstream media and in policy discourses.

It was in the early 21st century that the official toponyms "South Parkdale" and "Roncesvalles" began to replace the totalizing language of Parkdale, understood as having a north and south dimension in the city's administrative nomenclature. These changes in naming went hand-in-hand with larger processes that socially and economically produce "difference" between them as a natural and self-evident "fact" (Teelucksingh, 2002). The existing literature on gentrification in Parkdale has trained attention on residential gentrification (Slater, 2004, 2005; Whitzman, 2009; Whitzman & Slater, 2006),[2] and has

[2] Whitzman's work (2009) is a partial exception, in that her research emphasizes representations in planning discourse and in media. My emphasis is somewhat different, in that I am interested in understanding the ways in which expert knowledge pertaining to life and health impacts these neighbourhoods. In this sense I am not

called attention to the economic and class-based process whereby housing prices and household and individual income have risen since the 1970s in areas north of Queen Street, while falling in area to the south (Hulchanski, 2010; Masuda et al., 2012; Slater, 2004; Whitzman, 2009). To a lesser extent, research has also focused on the processes of environmental racialization through which difference is produced between these spaces (Masuda et al., 2012; Teelucksingh, 2002).

Importantly, this past research has highlighted the class-based dynamics through which certain types of housing are privileged, both by market forces as well as by the active intervention of municipal governments (Slater, 2004, 2005; Whitzman, 2009). This creates a dynamic whereby certain types of families, bodies, and lifestyles are privileged, while others are displaced (Mazer & Rankin, 2011; Slater, 2004, 2005; Whitzman, 2009). In this work, the emphasis has been on a broad and fluid understanding of "Parkdale" as encompassing areas both to the north and south of Queen Street. For example, Teelucksingh (2002) argues, based on her participatory mapping research in the area, that "it is possible to see that there are ongoing social processes that sustain the division between North Parkdale and South Parkdale" (p. 132). Moreover, says Teelucksingh, such spatial distinctions are "part of the dominant social order that racializes 'multicultural' people in South Parkdale, in contrast to the perceived whiteness in North Parkdale" (2002, p. 132; see also Mazer & Rankin, 2011).

As with gentrification more broadly, these processes of racialization and differentiation are not merely local. They can be understood in relation to how cities respond to the new economic realities of "globalization." Cities are increasingly pitted against one another in what is framed as a global economic competition to "attract and retain talent"

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concerned *only* with forms of expert knowledge that directly represent these areas, but also with expert knowledge pertaining to the relationship between health and local space more broadly.

(Gertler et al., 2002). Here, under the influence of high-profile academics like Richard Florida, the most important resource for globally competitive economies is understood to be highly educated, skilled, and (potentially) mobile knowledge workers (Blomley, 2004; Valverde, 2012). The global competition for talent shows up at the national scale, such as in efforts cultivated by the Chretien-Martin Liberal Government, to "sell" Canada as a haven of diversity through immigration and employment equity policies (Abu-Laban and Gabriel, 2002). However, the competition for global talent and tourist dollars is also apparent at the level of the city and even the neighbourhood (Valverde, 2012, p. 34). As Geographer Nicholas Blomely writes: "although place promotion has a long pedigree, the mobility of investment has encouraged many city governments to engage in more aggressive programs of place marketing, positioning themselves as platforms in an emergent economy of flows" (2004, p. 30).

The production of neighbourhood-level distinctiveness and value through forms of expert knowledge about these west end neighbourhoods has not been given sufficient attention. This chapter and the subsequent one contribute to the foregoing discussions by an analyzing knowledge that shapes difference and distinction in Parkdale. In contrast to the studies discussed above, the aim here is not to address the extent to which Roncesvalles and Parkdale are "distinct" spaces in the experience of people who live and work there. Such participatory research, as pursued by Mazer and Rankin (2011), Teelucksingh (2002), and Masuda et al. (2012), provides invaluable insights into the ways in which official boundaries and land use designations dividing north from south both shape and are shaped by peoples' subjective relations to these spaces, and also sheds light on the ways in which these boundaries are contested. Rather, the aim is to show how distinctiveness is produced in relation to the problems of healthified urban governance.

The question of district distinction is a phenomenon that is separate, but related to, questions of difference and diversity. Valverde (2012) notes that while Toronto was "for many years impervious to … design trends" which have seen the beautification of urban space, this has begun to change as competitive practices of district distinction are increasingly normalized. In Toronto, Valverde writes, sidewalks were

> for many decades made of rectangles of standard grey concrete… the public spaces of the city looked the same throughout: efficient but dull, functional but ugly, safe for pedestrians but cheaply made. However, in recent years, in Toronto, as in many other cities, many neighbourhoods in search of 'distinction', particularly those geared to promoting tourism or niche boutique style shopping, have persuaded city officials and politicians to embellish the sidewalk with cobblestone style bricks, coloured tiles and other aesthetic features. The same quest for district distinction has given us veritable forests of expensive looking lampposts and planters for flowers and small trees." (p. 34)

These design changes are often associated with the partial privatization of public space, as, for example, when Business Improvement Areas (BIAs) brand a place and undertake to privately govern how space can be used, and by whom. While these undertakings "do not at first sight seem to include neoliberalism, or even the economic entity that is 'privatization,'" these entities are "not purely physical. They are simultaneously physical, economic (a public-private partnership is generally used to fund the embellishments), discursive/aesthetic, and… legal" (p. 34). Furthermore, such embellishments are a "visible embodiment of a larger political process, namely, municipal encouragement of competition among neighbourhoods" (p. 34). For Valverde, the officially sanctioned quest for district 'distinction' "stands in sharp contrast to the post-war consensus about treating all sidewalks equally. The politico-legal infrastructure that supports microlocal beautification projects has the effect of increasing inequality between neighbourhoods – since the drab inner suburbs now look even drabber" (p. 34).

We can see the dispersion of these dynamics in the quotes that form the epigraph to this chapter. Roncesvalles is depicted as desirable as both a local and global tourist destination, as a place where the creative class can "snap up homes" and a trigger for an influx of "quirky indie shops." Further, as we saw in the previous chapter, one of the benefits of Wellbeing Toronto is explicitly articulated as its ability to allow transnationally mobile workers moving to Toronto to make decisions about where to live based on the availability of an extraordinary amount of data made publically available at the neighbourhood scale, that is, to produce their own objective assessments of the "best neighborhood to live in."

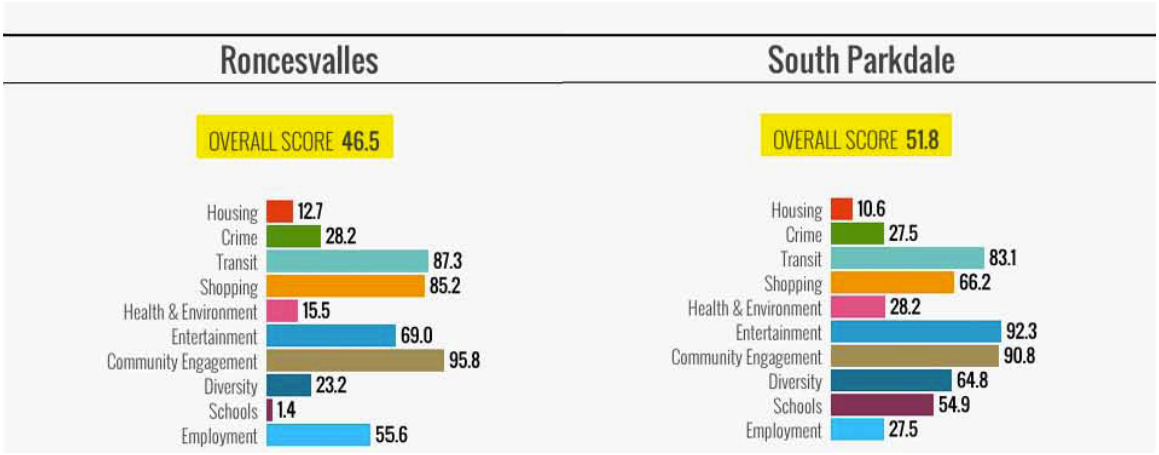


Figure 5.1 Visualizing Distinction: South Parkdale (#85) and Roncesvalles (#86). (Source: *Toronto Life*, 2013. Reproduced with permission).

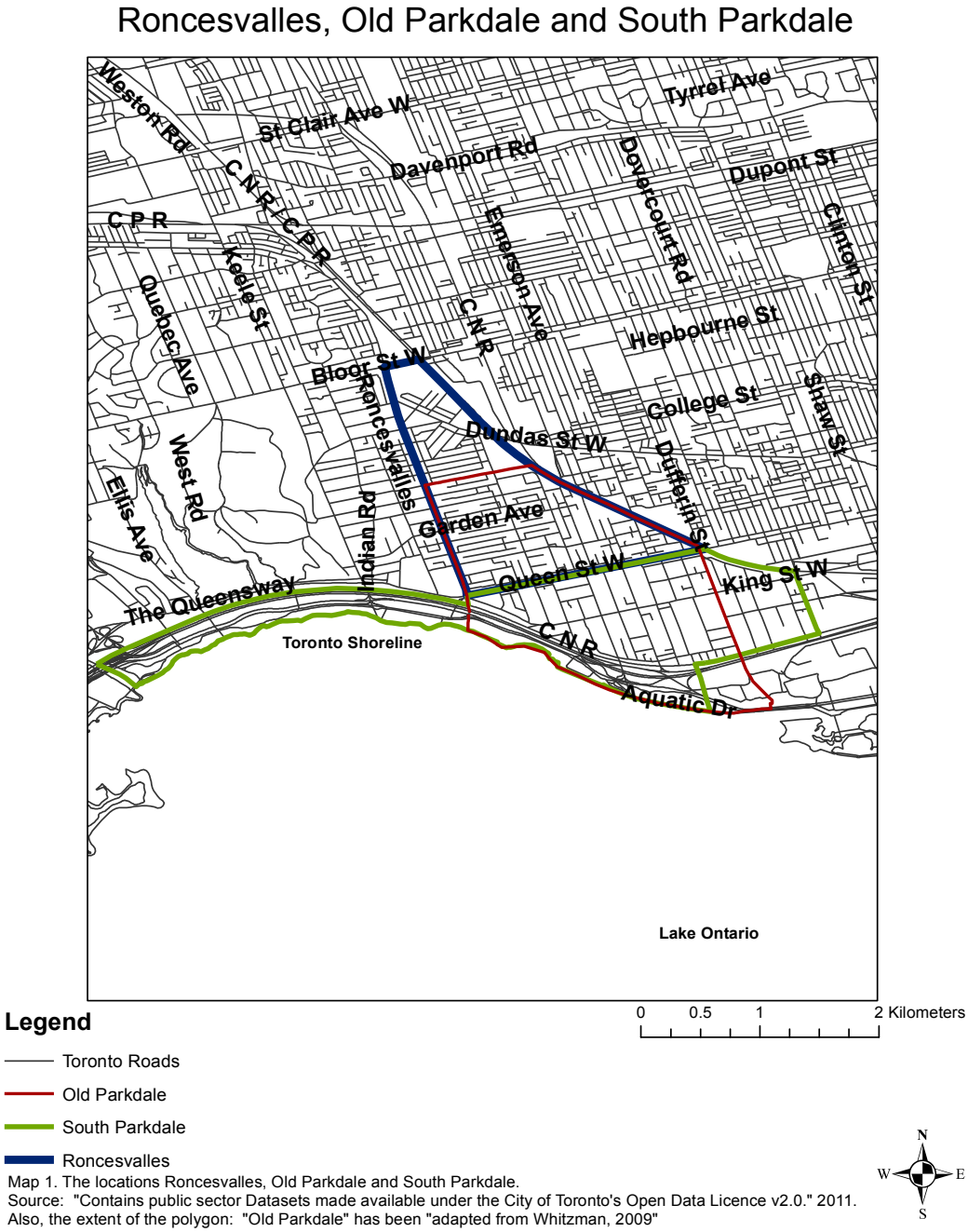
Experts have conceptualized the official neighbourhoods of South Parkdale and Roncesvalles in relation to measures pertaining to equity, child development, and livability. According to the City of Toronto's 2014 equity rankings, South Parkdale is one of the city's 31 neighbourhoods which requires "immediate attention" in the forms of "targeted investment" and "monitoring and evaluation" in order to "improve wellbeing across all neighbourhoods" (City of Toronto, n.d.-b). The 31 neighbourhoods were chosen because they scored less than the 42.98 equity benchmark established by "a team of experts"

(Doolittle, 2014). Their scores were "derived from 15 indicators of neighbourhood inequity across five thematic domains" (City of Toronto, 2014, p. 4) and were "based on a social determinants of health model" (p. 4). The classifications include unemployment, low income, high school graduation, municipal voting rate, walkability, healthy food stores, green space, and rates of diabetes (pp. 5-6).

Roncesvalles, South Parkdale's neighbour immediately to the north, is safely above this baseline equity benchmark. Similarly, as we saw in the previous chapter, Mothercraft, in its population health-inspired Early Development Instrument (EDI) assessments of childhood development, highlighted these two neighbourhood areas as both having high levels of "social risk," but also noted that they differed on measures of "optimal" childhood development. Interestingly, by contrast to these two sets of rankings, in an exercise undertaken by the University of Toronto's Martin Prosperity Institute and published in the Real Estate section of *Toronto Life* (see Figure 5.1, above), Parkdale scored just above Roncesvalles in an assessment of the "best places to live" in the city (D'Cruz, 2013). Are these results contradictory? Or do they perhaps signal the area as a "good place to invest," not only in property, but also in the health and biological life of the people who live and work there?

3. A Brief History of Parkdale

The historical Village of Parkdale was annexed by the City of Toronto in 1889, 10 years after its incorporation as a village. It thus became one of Toronto's first commuter suburbs, located just north of Lake Ontario and approximately five kilometers due west of City Hall (Slater, 2004, 2005; Whitzman, 2009). In conformity with late 19th century ideas about the appropriate type of place for psychiatric institutions, which emphasized the virtues both of a



Map 5.1 Roncesvalles, Old Parkdale and South Parkdale (Schuman, 2011).

rural setting and a location close but not too close to the amenities of city life (Dear & Wolch, 1987), Parkdale was also home to the Provincial Lunatic Asylum, as it was then called. The provincial asylum, which opened in 1850, was just beyond the city limits at that time. The village of Parkdale was established on lands already settled and subdivided to the west of the psychiatric institution lands. By the late 19th century, both the Village and the Asylum had been absorbed into the boundaries of the city.[3]

According to Slater (2004), popular lore holds that in the late 19th and early 20th centuries Parkdale was an essentially middle-class suburb of "Victorian and Edwardian manors" until the development boom ended with the onset of the Depression in the early 1930s. The suburb is remembered in official discourse as a desirable location for white, middle-class settlement until that time, with its proximity to the lake and the advent of the opening, in 1922, of one of the largest public works of the time at Sunnyside Pavilion (Whitzman, 2009). This earned it the informal titles of "Village by the Lake," "Coney Island North" (Slater, 2004, 2005), and perhaps most enduringly, the "Floral Suburb" (Whitzman, 2009).

Geographer and planning scholar Carolyn Whitzman (2009) argues that Parkdale's history can be "divided into three distinct eras" (p. 16): the "suburb" (late 19th and first decade of the 20th century), the "slum" (interwar to post-War period), and the gentrifying "urban village" from the 1960s onward. The first period, when Parkdale was a middle- and upper-middle-class commuter suburb of Toronto, runs from the time of incorporation to about 1912. Here, the image of the "floral suburb" is a foundational one first appearing in a

[3] In response to overcrowding at the Queens Street asylum, in 1891 a new "branch" of the asylum was opened in Mimico/New Toronto, on the grounds of present-day Humber College Lakeshore Campus. This had important implications for the later 20th century social geography of Parkdale, as we will be discussed below.

lengthy article in the *Globe*, reporting on a large tree-planting event marking the village's incorporation on May 17, 1879.

> Saturday, 17 May 1879, 'was a red-letter day in the western, or as it has now been christened, the 'Floral' suburb of Parkdale'. The Village Improvement Association, made up of prominent families in the newly incorporated municipality, organized a tree planting ceremony…. Fifty saplings, donated by the village's reeve, nursery owner John Gray, were muscled into the hard spring ground along eight streets by an estimated six hundred men women and children…. Afterwards, the crowd repaired to the grove owned by a lawyer named Maynard to indulge in well-deserved lemonade and cake while listening to local musicians. A speech made by Reeve Gray on this occasion referred to Parkdale as the Floral Suburb. The name stuck: Parkdale continued to be called the Flowery Suburb well into the twentieth century, and the phrase was recycled in the 1970's to refer to the neighbourhoods past glory." (Whitzman, 2009, p. 62, cited in the *Globe,* May 19, 1879)

Whitzman writes: "The tree planting ceremony was a great success in achieving its underlying goal: to present an image of progress, natural health, and moral virtue to potential purchasers of property" (p. 62).

According to scholars of the area, there are four key post-War developments which had a major impact on the social geography of the area: the construction of the Gardner Expressway, de-industrialization, changing immigration patterns to the City following national immigration policy reform in the 1960s, and the de-institutionalization of psychiatric in-patients from the Queen Street Mental Health Centre and the Lakeshore Psychiatric Hospital (formerly the Provincial and Mimico asylums, respectively).

In order to make way for the Gardener expressway, built between 1955 and 1962, some 70 homes in the southern part of Parkdale were bulldozed (Whitzman, 2009). According to Whitzman (2009) and Slater (2005), the mid-century depiction of Parkdale as a "slum" helped to make this possible. Beginning in the early 20th century there began to be controversies in Toronto about higher-density residential dwellings, in the form of apartment buildings "which were described by local politicians as 'breeders of slums'"

(Whitzman, p. 16). This debate had the effect of concentrating attention on Parkdale, which was, by 1915, home to one third of all of Toronto's apartment housing (Slater, 2005). Thus, by the end of the Second World War, writes Whitzman, "Parkdale's status as a declining area was by then taken for granted in planning documents and in newspaper coverage" (p. 17). The "slum" label took on increasing political/ideological significance in mid-century when the "floral suburb" of Parkdale now found itself in the path of a different kind of suburban vision. In the 1950s "Toronto became a prime site of experimental modernist planning" where "expressways leading to suburban expansion were seen as signs of progress" (Slater, 2004, p. 307). Thus, by the end of the 1950s the age of the neighbourhood was more liability than asset, as new suburbs beyond the city and the modernist expressways that transported people there came to dominate the logic of the times. At this time, older neighbourhoods like South Parkdale were portrayed as "obsolete and in the way of progress" (Slater, 2004, p. 2). The expressway also had the effect of cutting Parkdale off from the lake and the green space and other recreational facilities along its northern shore, as well as increasing traffic and traffic-related pollution (i.e. noise, exhaust) in the more southern parts of the area (Teelucksingh, 2002).

It was also in the post-War period that Parkdale began to experience de-industrialization. Early Parkdale had included "a mix of light and heavy industry, including a very large rubber plant and some commercial development" (Teelucksingh, 2002, p. 125). The industrial lands were mostly in areas near the northwest and southeast edges. During the Second World War "most of the residents of Parkdale found employment in factories and businesses in the community that had switched over two wartime production" (p. 126). De-industrialization was bound up with changes in housing stock, as well as a changing employment base towards the provision of services (Teelucksingh, 2002). In the 1970s

property redevelopment became attractive in Parkdale, due in part to the "rent gap" (Smith, 1996) or the relatively low property prices in the area, as compared with the rest of the city. According to Whitzman (2009), Parkdale was one of the last places in the urban centre where young, middle-class families could afford to purchase Victorian and Edwardian homes. At the same time, de-industrialization made relatively inexpensive brownfield sites available for new developments on lands that were attractive for their proximity to the urban core and with good existing amenities, such as public transit and parklands (Teelucksingh, 2002). In addition to new residential condominium development (Kern, 2010; Teelucksingh, 2002), de-industrialization in the 1980s also made room for the creation of a large green space near the rail lines which form Parkdale's northern border. Today the park includes tennis courts, a fenced dog park, a large natural ice rink in the winter, and a year-round weekly farmers' market. Thus the area has become attractive for investment by property developers and middle- and upper-middle-class families (see Ley, 1996, on the significance of proximity to "environmental amenities" such as parks and waterfronts, as well as the presence of tree-lined streets for the pattern of gentrification in Toronto). In the southeast, de-industrialization made way for the creation of Liberty Village Business Improvement Area as a "creativity hub" of new media outlets and artists' studios, through a partnership between the Toronto Economic Development Corporation and Artscape (Boudreau, Keil, & Young, 2009; Weiditz, 2007). "It is unclear, however, how the surrounding area of Parkdale benefits from this reconversion" (Boudreau, Keil & Young p. 190).

From the mid-1950s to the late 1970s, the de-institutionalization movement saw hundreds of psychiatric patients released "into the community" with virtually no social support (Dear & Wolch, 1987). In their book entitled *Landscapes of Despair,* Dear and Wolch document the effects of de-institutionalization in Ontario and California, which they

describe as a "well intentioned effort to remove the mentally disabled physically handicapped, mentally retarded, prisoners and other dependent groups from asylum and similar places of incarceration" (p. 3). The authors do not argue for re-institutionalization. Rather, they seek to show what went wrong, and how this policy initiative resulted in poverty and homelessness for many of the formerly institutionalized persons. Further, they show how particular settings, such as Parkdale, came to be home to large "service dependent populations in the city" (p. 3).

In the mid-1950s, as part of a broader provincial and international shift in the dominant knowledge regime pertaining to psychiatric treatment, as well as ongoing concerns about overcrowding, the Queen Street Mental Health facility began to introduce outpatient programs (Barc, 2011). In the 1970s, as the de-institutionalization movement continued to emphasize community-based treatment, the Queen Street location of the hospital was demolished and replaced with new buildings, and the Lakeshore branch of the hospital was closed entirely. Outpatient services for both institutions were to be centralized around the Queen Street location. Services, however, were woefully inadequate. Thus, as with the experience of de-institutionalization in other areas, a major outcome was that of mass homelessness of formerly institutionalized psychiatric patients. In the case of the Queen Street and Lakeshore Hospitals, this had the effect of concentrating poverty and homelessness in the Parkdale area, where the services that did exist were located. This, in turn, produced its own cascading effects, as the presence of a large underserved population spurred the emergence of more kinds of services, as well as other forms of housing such as group homes and illegal bachelorettes (Dear & Wolch, 1987). Thus, in the 1970s the area south of Queen Street saw the construction of high-rise apartments as well as social housing "in response to income needs… including those established for outpatient psychiatric care,

and/or operated by group home agencies" (Whitzman, 2009, p. 127). As Dear and Wolch further argue, these features of the neighbourhood (i.e. relative abundance of inexpensive, sub-standard housing) in turn acted as their own draw for others facing homelessness, poverty, and mental illness.

This period also saw the growth of stigmatizing portrayals of the area as a space of disease and delinquency, as the mainstream press reported on "concerns about the growing number of 'boisterous welfare recipients, drunks and drug addicts' inhabiting cheap apartments and rooming houses" (Whitzman, 2009, p. 3, citing the *Globe and Mail*, 1972). Noting that these processes are not absolute, but rather riddled with contradictions, Whitzman points to media representations in which "as early as 1970 Parkdale with its charming hundred-year-old houses, streets lined with mature trees and history as a well-to-do suburb" was also being "promoted by urban redevelopers eager to attract middle-class homebuyers" (p. 3). It is around this time that the "third era for Parkdale's image, that of becoming an urban village, began. […] This period has seen the neighbourhood described, in local government reports and in news coverage, as simultaneously gentrifying and becoming a social service ghetto" (Whitzman, p. 17). Thus, it is also in this third "era" that Parkdale's history began to gain renewed cachet. Beginning in the 1970s and continuing well into the 1990s, Parkdale, given the age and style of the houses and the lower asking rates compared to many other neighbourhoods with Victorian and Edwardian homes, began to be seen, once again as a desirable place for middle-class homeowners (Whitzman, 2009).

By the 1970s, the area was therefore increasingly portrayed in terms of both decline and rebirth. On the one hand, it was "stigmatized" by mainstream Toronto (Masuda et al., 2012), and on the other, it was promoted by property developers, real estate agents, and the city as a good place to invest and as a good place for middle-class family home ownership.

This tension became increasingly spatialized and racialized across the north-south boundary of Queen Street (Teelucksingh, 2002). It also became bound up with a concerted effort on the part of some business, property development, and real estate interests to rebrand the areas north of Queen Street as a separate neighbourhood, distinct from Parkdale.

4. The Politics of Naming: The emergence of Roncesvalles Village

Even though the introduction of neighbourhoods as administrative geographies was to be apolitical, in the case of Roncesvalles and South Parkdale, the very process of naming proved otherwise. As we saw above, the fact that neighbourhoods have names that correspond to experiential features, such as a historical district or an ethnic identity, was part of the reason for using them: "nobody says 'my census tract is 720.11'" (I #12, personal communication, August 2015). That is a language that only experts speak. This raises the question of how an area gets its name. As will be explored in this section, the name "Roncesvalles" is political in at least three ways. First, it reflected the nomenclature of the local business association, as well as the publically stated preferences of real estate and property developers. Second, it erased the connection between the two areas as constitutive of historic Parkdale. Third, it made these spaces and their (new) names available for others to use, as for example in ranking exercises like that of *Toronto Life*. In all of these ways, and no doubt others, the politics of assigning boundaries were evident.

Beginning in the 1980s the nomenclature began to change in a way that brought a new way of thinking about Parkdale, both north and south. At that time, "[g]entrification of architecturally attractive areas [in the Village] displaced many lower income residents and … bifurcated the neighbourhood [as] tensions [emerged] between more affluent (predominantly

north of Queen Street) and poorer (south of Queen Street) areas" (Masuda et al., 2012, p. 1246; see also Teelucksingh, 2002). In 1986, the Roncesvalles Village Business Improvement Area (BIA) was established. At the time, the BIA encompassed only three blocks between Howard Park and Marmaduke (Henton, 1986). Today, the Roncesvalles Village BIA spans the entire one-kilometer stretch of the street.

According to popular lore the BIA movement is a Toronto-based invention, which began with the establishment of the Bloor West Village shopping/business district in 1970. Bloor West Village BIA is reputed to be the first of its kind in the country, established to combat the twin pressures of the suburbanization of shopping, as witnessed in the growth of malls, and the subway, which transported potential shoppers underground, away from the hyperesthesia (Howes, 2005) of the street-level shopping district (Yang, 2010). In the United States the first modern Business Improvement District (BID) was, arguably, "the Downtown Development District of New Orleans, which was established in 1975" (Briffault, 1999, p. 367).

With its origins in the 1970s, the BIA/BID movement grew and spread quickly in North American cities in the 1980s and 1990s (Briffault, 1999). By the 21st century it had become an internationally mobile policy based on the "model" experience of one or two Manhattan-based BIDs (Ward, 2006). A BIA/BID is "a territorial subdivision of a city in which property owners or businesses are subject to additional taxes" (Briffault, p. 369). Finances raised this way are used to fund a variety of activities, usually oriented towards drawing shoppers, tourists, and other business to the area by, for example, providing landscaping and street furniture or sponsoring events such as street festivals (Briffault, p. 369). "Business improvement districts (BIDs) and BID-like organizations oversee a growing amount of public space in an increasing number of cities" and are important actors in the

"revalorizing of the built environment" (Ward, 2006, p. 54). BIDs and BIAs therefore underscore the significance of property ownership in processes pertaining to the negotiation of appropriate understandings of what urban public space is, and who or what it is for (Ward 2006).

In Toronto many BIAs followed the lead of Bloor West Village by branding themselves as "villages" to emphasize the "'the small village in a big city'" shopping experience: "Shoppers enjoy 'the small village in a big city' atmosphere while shopping" (Yang, 2010). Today, "Roncesvalles Village" is one of the 73 BIAs listed on the website of the Toronto Association of Business Improvement Areas (TABIA). It is also one of 26 that uses the term "village" in their name.[4] The neighbourhood of South Parkdale contains two BIAs: the Parkdale Village BIA (established in 1978) and the Liberty Village BIA (established in 2001).

Neil Smith (1996) observed the importance of naming in his classic study of gentrification as a global and local phenomenon:

> Referred to as *Loisaida* in Puerto Rican Spanish, the Lower East side name is dropped altogether by real estate agents and art world gentrifiers who, anxious to distance themselves from the historical association with the poor immigrants who dominated this community at the turn of the century, prefer 'East Village' as the name of the neighbourhood above Huston street. (p. 8)

Moreover, as geographer Nicholas Blomley points out, claims to space must be enacted materially and discursively. Thus, by definition these enactments are not singular events, but must take place repeatedly, in order to remain valid, logical, and taken for granted by others: "the claim to 'my' land is sustained not only by the original act of acquisition, but by continuing acts, such as fence building, maintenance of the property and relations with my

[4] Toronto Association of Business Improvement Areas. Retrieved from http://www.toronto-bia.com/bias/index.php

neighbours" (2004, p. 50). A BIA is a claim to space and property by a group of businesses, who must reenact this claim in material and discursive practices which include district naming through the use of banners and posters as well as the maintenance of gardens, flower pots, sidewalks, and so forth.

The image in Figure 5.2 (below) shows posters displayed in the windows of neighbouring shops on the north side of Queen Street West in December 2012. These posters, which advertise the *act* of shopping, make completing claims to space: "Parkdale" or "Lower Roncy" (LoRo). As such, they are examples of the myriad ways in which competing claims to space and property are enacted. This section argues that while it may still be possible to find "I Love Parkdale" and "I Love LoRo" side by side on Queen Street West, it is increasingly unlikely to find the former, public declaration, "up on Roncy."

Figure 5.2 Shopping Wars: LoRo versus Parkdale. (Photo by author 12.13.2012).

According to a keyword search for the term "Roncesvalles Village" in the *Globe and Mail*, the *Toronto Star* and the City of Toronto archives, the first appearance of a reference to Roncesvalles as a "village" was in 1986 in an article announcing the establishment of the Roncesvalles Village BIA. This is significant because it marks the emergence of a shift towards naming a separate space that is "not Parkdale" (Guth, cited in MacKinnon, 1999). The second instance occurred in 1999 in an article in the Real Estate section of the *Toronto Star* announcing a new property development on Wabash Avenue. In it, the property developer is quoted explaining his express preference for the toponym Roncesvalles over Parkdale. Tellingly, the article leads with the following sentence: "Next to the railway tracks on the fringe of *gritty old Parkdale* rises a development of pristine Victorian-style houses" (MacKinnon, p. 1, emphasis added).[5] The imagery here is striking: whereas Parkdale is associated with industrialism, grit, and death, Roncesvalles is packaged as simultaneously "new" and "Victorian." The anachronism is overcome in the evocation of purity: here. "Roncesvalles" christens a re-birth, a re-discovery of a more virtuous past. At the same time, it denotes a spatial sensibility towards a part of the neighbourhood already firmly established as a focal point of capitalist development.

According to *Toronto Star* real estate writer Bob Aaron (2011), "there are now at least four different authoritative sources for naming and defining Toronto neighbourhoods and none of them completely agrees with any of the others." Both Aaron and the city employee cited above count David Dunkelman's book, *Your Guide to Toronto's Neighbourhoods*, as key among them: "a must buy for realtors, appraisers, surveyors, historians and mortgage

[5] Here, the "fringe" of Parkdale refers specifically to a pocket in the north, just east of Roncesvalles Ave., where present-day Wabash Avenue is located.

lenders, along with those of us who just love this wonderful city" (Aaron, 2011).[6] In the first three print editions of this book (1997, 1999, and 2002) the neighbourhood of "Parkdale" is depicted as encompassing lands north and south of Queen Street. By contrast "Roncesvalles Village" is mentioned only in one sentence, which describes it as a good place to shop for Polish foods (2002, p. 114). The print version of the book is now in its fifth edition (2011), and its neighbourhood descriptions are available online.[7] Currently, Roncesvalles Village has its own separate entry, with boundaries that conform to the city's administrative boundaries (see Map 5.1 above).

As the toponyms "Roncesvalles" and "Roncesvalles Village" have become more widely dispersed, "North Parkdale" also has faded from use. A search for "North Parkdale" in the city archives yields few entries after 1990, and none after 2003, suggesting a gradual displacement of one understanding of the area by another. Interestingly, the total records for the year 1990 consist of two photographs of the fading industrial landscape, by Toronto photographer Robert Teteruck.

The naming of the village of Roncesvalles went hand-in-hand with a growing emphasis on Parkdale as a site of urban decay. According to Whitzman (2009), by the 1990s Parkdale was being presented in the news media in terms of divergence, a neighborhood characterized by growing disparities between the privileged and the marginalized, "'an elegant reno next to a rundown rooming house'… a place that was simultaneously bowery and bohemia, ghetto and gentrified urban village" (p. 3, citing the *Globe and Mail*, August 2000). She recounts the following exchange with a real estate agent, around the year 2000:

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[6] Aaron, B. (2011, October 29). Turf war over who names the neighbourhoods. *The Toronto Star*. Retrieved from http://www.aaron.ca/columns/2011-10-29.htm

[7] Toronto Neighbourhood Guide, http://www.torontoneighbourhoods.net. For a Map of the West End, see http://www.torontoneighbourhoods.net/neighbourhoods/west-end.

> "Me: 'I've just finished reading a book that talks about Parkdale. Its called *Landscapes of Despair.'*
> Real estate agent (quickly): 'You can see why we prefer the term Roncesvalles Village.'" (p. 151)

Importantly, the city does not use the term "Village" in its naming of the areas, while Business Improvement Areas in both official neighbourhoods have added it, thus etching a trace of their former, shared history as a single village into the commercial landscape.

These divisions were similarly captured by the recollections of one informant with a long history of involvement with the area:

> [Roncesvalles] used to be a little bit more Parkdale-ish. A lot of the homes that are now single-family homes were flats, and/or rooming houses and it was really easy to find an apartment in this neighbourhood, you could share houses with friends and things like that. (I#6, personal communication, 2015)

For this informant, Roncesvalles and Parkdale are treated as separate spheres, with the former recently becoming an unaffordable and inaccessible place for single people to rent apartments. Here, the word "Parkdale" is used as an adjective for describing a particular kind of neighbourhood, one that is not dominated by single-family ownership, but instead has a diversity of tenancy options. In South Parkdale in 2001, 93% of the housing stock was rental. In the same period, north of Queen Street, on to the East of Roncesvalles Avenue, housing prices "doubled between 1996 and 2002…. According to a regular report distributed by a local real estate agent" (Whitzman, 2009, pp. 13-15).

Expert data presented similar divisions. By 1980 Parkdale was home to 48% of the city's total rooming house beds (Whitzman, 2009, p. 8). Since the 1970s the area south of Queen Street is one of the few inner city areas to have experienced a decline in individual income of greater than 20% (Hulchanski, 2010), whereas lands north of Queen Street have seen incomes rise at a comparable scale. According to census data, by the turn of the 21st century there were "large and growing disparities" within historic Parkdale: "one census tract

Figure 5.3 "*Coaling Facility, North Parkdale Looking North/East.*" Robert Teteruck, 1990. Reproduced with permission of the artist. City of Toronto Archives Fonds 1511, Item 18.

in the relatively gentrified area north of Queen Street had a median household income of $55,814, close to the Toronto CMA [Census Metropolitan Area] average, while another census tract south of Queen Street had a median household income of $23,070, with 45% of households defined as low income in the census" (Whitzman, 2009, p. 13). David Hulchanski's (2010) work with the Cities Centre at the University of Toronto provides a snapshot of the relationship between this local divergence and the broader city-wide growth in spatialized income inequality, between the now predominantly wealthier inner-city and the lower income suburbs within the city's geographic limits. Specifically, his work presents a rather dramatic picture of trends in the spatialization of income polarization in the GTA since 1970. In the Parkdale area we see adjacent census tracts where the trend is an increase

in income of 20% or greater in the tract north of Queen Street, and decrease of 20% or more in the tract south of Queen Street. Parkdale is thus part of a broader trend of income polarization within and between the "inner" and outer city in Toronto.

The emergence of the term "Roncesvalles Village" is therefore an important political transformation. It marks a movement away from stigma and towards the "small village in a big city atmosphere" that BIAs seek to produce, and suggests its suitability for middle-class family life.[8] As we can see, the image of distinction between the areas north and south of Queen Street in the areas of historic Parkdale is not one which is merely "described" by neutral observers, nor is it simply a matter of Parkdale continuing to be "stigmatized" by mainstream Torontonians (Masuda et al., p. 1246). It is an image that is actively produced by developers, real estate agents, and businesses. In this, processes of naming and branding a place as a commodity to be sold are part and parcel of economic and environmental patterns of distinction.

5. The Vital Politics of Gentrification: "Roncy Renewed"

"And above all else, they say the street must be green."

— Baute, 2009

"The end result is a street that is full of vibrancy and life – not just a way to pass through, but a destination in itself. Roncesvalles is a pedestrian-friendly place where neighbours can meet friends, stop to chat, and yes, to shop."

–- Roncesvalles Village BIA President John Bowker, 2011a

At the dawn of the 21st century the image of Roncesvalles as a village gained heightened significance as local interests took hold of an infrastructure redevelopment as an opportunity

[8] See Slater (2004) for an analysis of this way of defining space in Parkdale. Also, see Boudreau, Keil and Young (2009) for a discussion of how post-amalgamation planning emphasized both economic and population growth in the new City of Toronto. This provides important context to the emphasis on heteronormative familialism emphasized by Slater and by Keatinge and Martin (2015).

to reimagine the area along vital political lines. At that time, Roncesvalles Avenue was slated for a major infrastructure redevelopment by the City of Toronto. The project was aimed at coordinating the replacement of the streetcar tracks on Roncesvalles Avenue and that of the nearly 100-year-old water mains and sewer. The Roncesvalles Village Business Improvement Area became a key actor in the process. The BIA was essential in underscoring the importance of vitality and biological life as things to invest in and as valuable outcomes of the "renewal" process. In order to be an effective intervener in the redevelopment process the BIA sponsored the development of two organizations: Roncesvalles Renewed (2005-2011) and RoncyWorks (2011-present) (see Table 5.1 below for a timeline). The former organization was established to lobby the city for specific design and beautification elements favoured by the BIA and local residents' associations. The latter was established in order to organize the volunteer labour necessary to maintain design elements, such as gardens and trees, once they had been installed in the course of the redevelopment.

In 2003, the BIA commissioned architecture and planning firm Brook McIlroy to develop a Street Scape Strategy for Roncesvalles Avenue. The plan was to develop it in "consultation with businesses, residents and other stakeholders" and it was intended to help the BIA "navigate the changes facing the street" (Roncesvalles Village BIA, 2007). The BIA saw the infrastructure redevelopment project as a "unique chance…to advocate for improvements along our street" (Roncesvalles Village BIA, 2007) and to advance "a new model" of community collaboration with the city. It saw this as an opportunity to get support for creating "better sidewalks [and] beautiful public spaces." The plan was not commissioned as a "final vision" but rather as a tool for engaging the city in a dialogue about the future of the street.

Following this, in 2005, Roncesvalles Renewed was established. This group included representatives from the BIA as well as three local residents' associations and "other local residents with particular interests or expertise in urban planning and renewal, business owners, local institutions and political representatives" (veroncy for RoncyWorks, 2012b). The group was formed in order to continue to dialogue with the city to see its vision of the street realized. Specifically, the BIA and is offshoot organization, Roncesvalles Renewed, wanted to see the infrastructure redevelopment plan include street-level changes to beautify the street and make it more "green," and to reduce vehicular traffic in favour of a more pedestrian- and cycle-friendly environment.

The city developed five alternative proposals, including a "do nothing" option. Each dealt with how streetcar, pedestrian, bicycle, and vehicular traffic could be accommodated. "Do nothing" was included as a benchmark relative to which other alternatives were assessed (City of Toronto, 2009, p. 4). The four "do something" alternatives were as follows:

> Alternative #1: This alternative solution involves widening the east side sidewalk/boulevard, creating a parking lay-by on the east side and providing two southbound traffic lanes and one northbound.
>
> Alternative #2: … adds exclusive bike lanes in both directions and a parking lay-by on the east side, as well as two southbound traffic lanes and one northbound traffic lane. Sidewalk widths are decreased on both sides.
>
> Alternative #3: … provides a parking lay-by on both sides and one wide traffic lane in each direction. Sidewalk widths can potentially be increased depending where bump-outs are located.
>
> Alternative #4: … provides exclusive bike lanes and parking lay-bys on both sides of the street with one northbound and one southbound traffic lane. The sidewalk area is decreased on both sides of the street. (City of Toronto, 2009, p. 5).

Table 5.1 Timeline: The Redevelopment of Roncesvalles Avenue

1986	2003	2005	2007	2009	2011
Roncesvalles Village BIA is established	City of Toronto announces a coordinated infrastructure redevelopment (sewers, water mains, street car tracks) along Roncesvalles Avenue Roncesvalles Village BIA commissions architecture firm Brook McIlory to produce a proposal to "guide the process"	Roncesvalles Renewed is established The organization consists of members of the Roncesvalles Village BIA, as well as local residents and residents' associations The mission of the organization is to advocate for its vision of a beautiful shopping district at the City	Roncesvalles Village BIA expands to include entire 1.5-kilometer stretch of the street, on the east side	Beautification and streetscape redesign plan are added to the infrastructure redevelopment plan Funds for the additional project elements are raised by the BIA from its members, as well as from contributions from the federal government The BIA commits to the ongoing maintenance of beautification features, such as gardens, benches, and trees	Construction is completed Roncesvalles Renewed is disbanded A new organization, called Roncy Works, is established in its place by the BIA Roncy Works is the organization tasked with maintaining the features of streetscape beautification, now that they have been realized: i.e. gardens, benches, and trees Roncy Works consists of a volunteer labour force made up of members of the BIA, residents, and members of residents' associations

In the end the third alternative was selected because it "supports the BIA Streetscape Strategy, provides shorter crossing distances for pedestrians, acceptable conditions for cyclists and on street parking is allowed on both sides of the street at all times" (p. 5).[1]

Opponents of this vision of the street were mainly concerned with parking and traffic, as well as the significantly higher cost of the beautification elements such as gardens that were advocated for by Roncesvalles Renewed (City of Toronto, 2009, p. 4, 7; Baute, 2009).[2] As reported in the *Toronto Star* members of the organization, as well as the local city councilor, believed that a "pedestrian, cyclist and transit-user friendly street is the way to go" and could transform Roncesvalles "into a 'model village,' a paradise for pedestrians, cyclists and shop owners alike." Further, it had the added advantage of fulfilling the imperative to be green: "And above all else, they say the street must be green" (Baute, 2009).

In conformity with the imperative that the "street must be green," the realized project saw several significant aesthetic changes to the streetscape of the area, in addition to the infrastructure redevelopment. Specifically, 100 new trees of different species were planted in order to create "a thriving canopy of trees along Roncesvalles," and a series of gardens were added along the length of Roncesvalles Avenue:

> When plans for the reconstruction of Roncesvalles Avenue were in formation, trees and plant beds were one of the top features that residents and businesses wanted to see along our main street. So, when the sidewalks were reconstructed in 2011, the City installed 21 plant beds and several hydrants with the agreement that they be maintained by the Roncesvalles Village BIA. (veroncy for RoncyWorks, 2014)[3]

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[1] "Bump-outs" are essentially transit platforms which allow for level boarding of streetcars from the sidewalk. In this model, now realized on Roncesvalles, "transit, cyclists and vehicles share one general travel lane at mid block locations. At transit platforms cyclists will be directed to ride over the platform and then continue on the street. Cyclists will yield for transit loading and unloading…. Parking is permitted on both sides of the street in lay-bys" (City of Toronto, 2009, p. 6).

[2] This conforms to Valverde's observation of the extent to which, in Toronto, objections to planning visions are often voiced as concerns about parking and traffic. For Valverde this shows the limits of planning and zoning law for negotiating the very real challenges associated with a diverse city, and competing visions of what constitutes a "good" or the "best" use of space.

[3] RoncyWorks. (2014, September 12). Greening of Roncy Part 1 [Blog post]. Retrieved from https://roncyworks.wordpress.com/2014/09/12/greening-of-roncy-part-1/

In addition to capturing these opportunities, Roncesvalles Renewed established a "'buy local' campaign to help our businesses survive this major reconstruction of Roncesvalles" (veroncy for RoncyWorks, 2014).

Once construction on Roncesvalles was completed in 2011 there was no longer a need for an organization to negotiate with the city to see its vision of a beautiful shopping district realized. Thus, Roncesvalles Renewed was replaced by RoncyWorks, as priorities shifted "from planning and community outreach, to preserving and enhancing the collective investment in our shared public space" (RoncyWorks, 2016). A key aspect of this 'preservation and enhancement' is, as per the agreement with the City, for the 21 gardens to be maintained. This is now done by what appears to be the almost exclusively female volunteer labour force of RoncyWorks.[12] This organization is self-described as "a loose network of volunteers mostly from Roncesvalles Village, made up of neighbours, shop owners and organizations working together to keep Roncesvalles exceptional."[13] This reference to investment, an echo of the name "RoncyWorks" itself, is particularly interesting. A clever play on the notion of public works, it is infused with both a good dose of do-it-yourself ethos and an explicit and oft-repeated injunction to "all pitch in" (see Figure 5.4, below). But what exactly are "we" all pitching in on? The fact that the "public" in public works is displaced by the BIA brand of "Roncy" is surely a clue: this is the "capacious logic" of neoliberal public private partnership described by Valverde above. Through it, the resources of the city, the federal government, the BIA, and the unpaid labour of volunteers are all mobilized in the production of a particular vision of space, as well as a particular vision of the good citizen and/as good consumer.

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[12] See, for example, RoncyWorks. (2012, March 25) Roncy Sweeps [Blog post]. Retrieved from https://roncyworks.wordpress.com/category/roncyworks-2/page/3/.

[13] RoncyWorks, "About." Retrieved from https://roncyworks.wordpress.com/about/

In the discourse and debate about the future of the street, trees were a crucial aspect of how renewal and rejuvenation were conceptualized. Trees were positioned as bringing life itself to the street. In an act reminiscent of the late 19th century tree planting ceremony described by Whitzman above, which sought to mark Parkdale's birth as an "essentially desirable place for middle class homeownership" (Whitzman, 2009), the 21st century post-construction re-birth of Roncesvalles Avenue was also marked with the planting of trees:

> Roncesvalles Renewed has begun planting! After two years of construction, new trees were planted on Roncesvalles on Saturday May 14th [2011]. Every new tree on Roncesvalles is being planted in conditions where it will thrive and flourish for generations to come. Together with the existing trees, new trees will form a beautiful shade canopy. (Perks, 2015)[14]

This reference to "conditions where [trees] will thrive" is further elaborated in the article cited above about the construction project appearing in the *Toronto Star*:

> Roncesvalles Renewed wants to break with the city's traditional sidewalk tree planting, where, stifled in *coffin-like planters*, trees rarely live beyond five to 10 years. They have their sights set on a 'living sidewalk' built with soil cells and unit pavers that would allow roots to grow unrestricted, creating a leafy canopy while soaking up storm water runoff that often causes sewer overflow. (Baute, 2009, emphasis added)

Here, the connection between trees and life/vitality is two-fold. On the one hand, the fact that health researchers and city planners increasingly associate trees, as living things, with a host of environmental, social, and health benefits (Braverman, 2008) means that trees function as self-evident markers of health and wellbeing. For instance, Wellbeing Toronto includes "tree cover" as an indicator of environments that are conducive to wellbeing, and in the *Toronto Life*/Martin Prosperity Institute collaboration discussed in the previous chapter, trees and walkability are included as health indicators, along with colorectal cancer screenings, breast cancer screenings, diabetes prevalence, the number of regulated health

[14] Gord Perks, City Councilor, Roncesvalles Renewed. Retrieved from http://gordperks.ca/roncesvalles-renewed/. See also, Roncesvalles renewal a relief for neighbourhood. (2011, July 24). *CBC News*. Retrieved from http://www.cbc.ca/news/canada/toronto/roncesvalles-renewal-a-relief-for-neighbourhood-1.1093288

care providers, green space, and polluting facilities. Finally, the Urban HEART@Toronto tool explicitly codes "healthy" neighbourhoods—those with high degrees of wellbeing—as green (as opposed to yellow or red, which indicates less healthy neighbourhoods) based on, the availability of healthy food stores, education levels and voting behaviours, among other things. As such, trees and the work of "greening" space by planting and maintaining urban gardens, for example, is not just a metaphor about life in general or a nod to the philosophical assertion of the connectedness of all beings (although it may be both of these things). It is also a political gesture that can and will be counted and quantified in the increasingly prevalent efforts to measure the health-giving and health-detracting attributes of neighbourhoods. In this context, the reference to "coffins" (see also, Bowker, 2011a; kkkioski for RoncyWorks, 2011a) serves not only to highlight the importance of protecting the life of the tree, but also, by extension, the vitality of the humans who live work and play beneath the enhanced canopy. It also serves to position the type of planning—its materials and its process—with death. Concrete planters are the by-gone techniques of a by-gone era. Life, by contrast, is associated with the new techniques of the "living sidewalk," as well as the model of public private partnership (Rose, 1999; Valverde, 2012) envisioned by Roncesvalles Renewed and maintained by the volunteer labour organized by RoncyWorks:

> Eventually, the Roncesvalles commercial district will become a leading example of how community and urban planning had combined resources and ideas. This collaboration helped create a long-term strategy for sustainable tree planting…. In addition to ecological stewardship, consider all the future autumn strolls, envision the delightful brilliant fall colours, the burst of spring greens, seasonal blossoms, and inviting seating areas to relax among the trees and watch the world go by. Now we can fully appreciate the promise of those life sustaining young trees and the extra care that went into their planting and now their maintenance. (kkkoski for RoncyWorks, 2011b)

The author above points out that "Radiating off every heavily tree canopied street are 'redone Four Squares' that are highly sought after by perspective home-buyers" (kkkoski,

RoncyWorks, 2011b). These types of narrative depend on the association of all those other neighbourhoods, such as South Parkdale, that still have "traditional" sidewalk trees with death, coffins, and out-of-date planning techniques. Thus, it will be important to see how the politics of trees unfold as the Queen Street NIA project mentioned above unfolds in the coming years.

The role of spaces that are neither "state" nor "market" in their entirety has also taken on renewed significance in the late 20th and early 21st centuries, in the form of renewed emphasis on "community." Nicholas Rose (1999) writes of "community" as kind of third space of governing unique to "advanced liberal" regimes. Here, community is understood to be a space of "semantic and programmatic concerns" bound up with "the powers of a territory between the authority of the state, the free and amoral exchange of the market and the liberty of the autonomous 'rights-bearing' individual subject" (p. 167).

For Rose, the "community of the third sector, the third space, the third way of governing not primarily a geographical space, a social space, a sociological space or space of social services thought it may attach itself to any or all such spatializations" (1999, p. 172). It is, first and foremost, "a moral field binding persons into durable relations. It is a space of emotional relationships through which individual identities are constructed thorough their bonds to micro-cultures of values and meanings" (p. 172). Importantly, for Rose, this emphasis on community as both an extra political, natural space and a crucial locus in the contemporary "diagram of government" is also connected to notions of active citizenship, and to a revaluation of "civic republicanism." Here, this vision of the active citizen is deeply connected to a critique of the bureaucracy of state and market, as well as the historical trajectory of capitalist social relations which saw the breaking apart of "traditional" social bonds and attachments and a concomitant privatization or inward turn of the political

subject, as a subject of "negative liberty." Thus, in contrast to this (suburban, single-family dwelling, consumerist) citizen subject, that of the urban, community-minded citizen, actively involved in producing a vision of the public good through "successful economic government," is defined as someone who recognizes "the significance of relations of interpersonal trust, local and community based trading networks, collaboration amongst enterprises sharing a commitment to their particular geographical region" (p. 168).

The images below in Figures 5.4 and 5.5 show examples of signage that now regularly appears in the 21 gardens. These can be read as fulfilling multiple functions. On the one hand, they make the unpaid labour of maintaining the garden visible, by putting the RoncyWorks logo and web address on the sign. They also function to brand the area as "Roncy" while simultaneously suggesting a line between appropriate and inappropriate forms of behaviour, such as smoking and walking in the garden areas. Other similar signs declare the gardens to be "foot free zone[s]: plants at work," and serve to recruit new volunteers to the cause: "seeking local green thumbs for tender loving care and a committed relationship. Roncy works when we all pitch in" (RoncyWorks, figure 5.4 below).

In this sense the "renewal" project can be considered an instance of environmental gentrification through the body (Kern, 2015a), made possible by political and financial collaboration between local residents associations, the local business association, the city, and the federal government (Baute, 2009). However, in contrast to the situation described by Kern and others, wherein environmental gentrification takes place as a result of the remediation of low-value land to higher-value use, or where a "toxic past" is mobilized as an asset, in the case of Roncesvalles, the "Roncesvalles Renewed" campaign was oriented towards producing a more optimal, vivified future for the area which was not directly predicated on the image of "cleaning up" an industrial past. This is not to deny that North

Parkdale has an industrial past, but rather to argue that that past has been all but forgotten by the 21st century landscape that it need not be referenced in order to buttress the vital politics of life optimization characteristic of this latest instance of gentrification. The struggle between life and death that this narrative of renewal is predicated on is, rather, produced by juxtaposing conventional planning and design against the organizations own distinct and "life optimizing" vision for the street scape.

Figure 5.4 No Boots, No Butts, No Problem. (Photo by author 06.19.2014).

Critical gentrification scholars have called attention to the language of "rejuvenation" as an ideological tactic designed to associate this form urban change with vitality and 'life itself.' In the case of Roncesvalles, the language of renewal, rejuvenation, and rebirth are strongly associated with the incorporation of aesthetic elements aimed at re-embedding the natural world (external nature) into the urban landscape: an enhanced "healthy" tree canopy

and gardens, well maintained and free of class-coded "boots" and [cigarette] "butts." Going beyond the imagery of renewal and rejuvenation to invoke (re)birth itself, Roncesvalles Renewed proclaims that "it took a village to raise that baby!"

> Several members of RoncyWorks were involved in the process and are pleased to report that Roncy's development history is intact, safe and on the cutting edge of experimental projects. For example the Greening of Roncy by local volunteers and the success of the Cigarette Litter Prevention Campaign is inspiring other neighbourhoods. (kkkoski, 2014 for RoncyWorks)

Similarly, in her research into trees and urban planning in North American cities, legal scholar Irus Braverman (2008) argues that the contemporary emphasis on the importance of urban trees can not be explained by their (debatable) environmental utility alone. In an ironically titled essay, "Everybody Loves Trees," she shows how the treatment and construction of trees as objects that ought to be loved universally functions as a technique for the indirect policing of urban space, by shaping and morally favouring certain kinds of use of space, types of activities, and forms of bodily behaviour and comportment. It therefore seems appropriate to ask: who can embody the figure of the good citizen in this model village? As Mazer and Rankin show in their research on gentrification in West Toronto, the experience of diminishing social space for poor and marginalized people is real and pervasive:

> For some the anxiety concentrates most significantly on the power of judgment and harassment to control their use of *public* space [i.e. as opposed to the private space of dwelling] – whether it is 'the eye' one gets while 'just sitting and reading… in the park', or the 'disgust on [people's] faces when they walk by on the streets' or the 'whispers'. Such judgments are experienced as acutely uncomfortable. Even if tenants recognize that that such interactions result from a faulty conflation of poverty and mental illness with crime, drugs, and prostitution – which many of them did in our interviews – the judgments have a shaming effect that cuts off access to public spaces. (2011, p. 829, emphasis in original)

In the images of Roncesvalles offered in the travel publications that are cited in the epigraph to this chapter, the image crafted by efforts of the BIA, of a Roncesvalles "renewed" and

"rejuvenated" in the wake of a lengthy construction project which saw the area's century-old water mains replaced between 2009 and 2011, is affirmed. Since completion of the construction project, Roncesvalles *Village* has been recognized and acclaimed by planners, the press, and the city as a model, livable, "small town in a big city" community. In the immediate wake of the construction project it was featured as a travel destination in the *New York Times*, described as one of Toronto's "most engaging strolls" (Kaminer, op. cit. p. 194). The following year, Roncesvalles was a finalist in the Canadian Institute of Planners' "Great Places in Canada" contest. And, most recently, the May 2016 edition of Toronto-based

Figure 5.5 "Keep the Soil Clean." (Photo by author 06.11.2016).

Porter Airlines' in-flight magazine featured the neighbourhood as a travel destination, locating it as "[t]ucked between the hipster bars of Parkdale and leafy High Park, Roncesvalles (Roncy to locals) is a family-friendly neighbourhood with charm to spare"

(Freed, op. cit. p. 194).[15] Importantly, *The Grid*'s characterization of Roncesvalles as the "most perfect corner of Toronto that we have left" is incorporated into the BIAs website banner. Of course, this framing—"that we have left"—implies that Roncesvalles' current identity and morphology is an historical artifact, not the recent invention of an "innovative" 21st century experiment with public private partnership in planning.

In all of these cases a similar image of the neighbourhood emerges: small town in a big city, with young "hip" families replacing the Eastern European working class. Also notable is the near absence of any reference whatsoever to "Parkdale," past or present. Thus, whereas for Parkdale the "mythical narratives" of the areas as a middle-class "jewel" with "leafy streets" (Whitzman & Slater, 2006, pp. 684-688) were crucial to its reinvention as a family-friendly "village" in the late 20th century, for Parkdale cum-Roncesvalles a near complete forgetting of this shared history seems just as essential.

The homogeneity of these depictions is paralleled by that of the streetscape itself, where flowers and the etho-aesthetic of "green" and "clean" also feature prominently on storefronts and websites, in addition to the public and quasi-public spaces of the sidewalk. These days, on "Roncy," even the litter bins are sometimes flower-adorned, as in the image below (see Figure 5.6) where someone has cleverly converted "litter" to "glitter" by covering the entire side of a city litter bin with glittery stickers in the shape of a large sun beating down on flowers (bottom right), among other designs. On the one hand, this is a fun, lighthearted thing to do (and I for one certainly smiled when I encountered it). However, litter and its presence or absence in the urban landscape is political as politicized as a marker of class, cleanliness, health, community pride, and entrepreneurialism. The adornment of this litterbin is interesting to consider the context of the systematic counting of pieces of litter

[15] I would like to thank Nairne Cameron of Algoma for brining this to my attention at the 2016 Canadian Association of Geographers conference in Halifax, Nova Scotia.

visible in the yards of all of North York's nearly 800 Enumeration Areas formed the basis for one of the maps in the Community Mapping study discussed in Chapter 4. Furthermore, as Masuda et al highlight, environmental racism and racialization sometimes manifest through everyday gestures such as "inferior waste management and park services":

> We see the discrimination in Parkdale from the waste management people… [in wealthier neighbourhoods] the garbage truck comes and after he is done his job he leaves everything nice and organized… They come to [Parkdale] and we see what they are like here [referring to a photo of a garbage strewn alley]. (Community researcher, cited in Masuda et al., 2012, p. 1249)

Presumably, tidy bins make better canvases, and (g)litterbins call out for greater care than litterbins. Assuming that all that glitter is not really just more litter.

These questions take on heightened significance when we consider that Parkdale's designation as a Neighbourhood Improvement Area, based on its equity ranking score, has coincided with the unfolding of a planning study for Queen Street West, between Bathurst and Roncesvalles. This section of Queen West is designated as an Avenue, which means that it is one of the "important corridors along major streets where reurbanization is anticipated and encouraged to create new housing and job opportunities, while improving the pedestrian environment, the look of the street, shopping opportunities and transit service for community residents" (Toronto, 2010). It will therefore be important to see how the politics of bodies and trees unfold here. Notably, in another study of city redevelopment, the Roncesvalles example of community partnership is cited as a model for how to proceed with such projects.

Figure 5.6 Litter or Glitter? (Photo by author 12.10.2012).

6. Conclusions

This chapter examined the birth of the Village of Roncesvalles as a name, as a site of governance, and as a perceived reality tied to community organizing. The effects of these processes have been to produce a sanitized urban form that strives to separate or rid itself of the problematic aspects of late capitalist development in the city. The dislocations of late capitalist urbanism are banished from Roncesvalles Village, a perceived ideal and material place, while they are simultaneously normalized as belonging to other parts of the city and other neighbourhoods. The production and maintenance of this ideal therefore hinges on devalourizing the lives and bodies of those who do not easily fit with or succeed in the daily demands of capitalism and the "appropriate," if partial, ways to transcending these demands

through "retail therapy," the consumption of raw juice, or volunteer participation in landscaping and beautification on behalf of the BIA, for example.

The case of Parkdale, and the birth of Roncesvalles Village from within it, resonate with, but also extend, the work of Marxian scholars on the ideological nature of the urban landscape. In his work on space, class, and alienation in Los Angles, geographer Kanishka Goonewardena (2005) developed the concept of the urban sensorium to capture the ways in which what the city *is*—its experiential reality—is mediated by space. The Los Angeles that is experienced by an upper-middle-class entrepreneur stuck in traffic on an expressway is fundamentally different than that of someone without a roof over his or her head and living on "skid row." Importantly, for Goonewardena (2005), this is in part because of the ways in which urban planning systematically renders skid row invisible to the more affluent residents: it is literally invisible from the vantage of the freeway. Similarly, Don Mitchell (1993) advances the notion that the urban landscape is itself a hegemonic force. He does this by focusing on the dynamics of capitalist urban development, such as gentrification, which displace not only people but also the traces of their history and the specificity of their material worlds in the endless drive to remake, rebuild, revitalize, rejuvenate, and so forth. Space and landscape therefore have the tendency to become their own sensorial bearers of relations of truth and power: "as the landscape becomes stabilized, its very ordinariness tends to mask the struggles that constituted its form" (Mitchell, 1993, p. 7).[16] But the tourist map view of the city and its uses is not the spontaneous creation of capital: it is also the product of the actions and activities of a whole constellation of "experts" and other

[16] The meticulousness of this process is captured by the artist Jorge Otero-Pailos in *The Ethics of Dust*. According to the author, the discoloration of buildings, a sedimentation of not only industrial pollution, but also the sweat, labour, and life energy of those who sold their labour power to produce that pollution (among other things), is erased in the fetish for tall and shiny glass buildings, cleaned regularly by the window washers of the new post-industrial labour force.

interested parties.

Thus, we can also see that certain dimensions of the lived reality of Parkdale are not so much buried and rendered invisible as they are normalized as belonging "elsewhere." In this case, they belong to Parkdale, not Roncesvalles. Roncesvalles is the place where you go to buy a home on a leafy street, or take in a yoga class, an organic juice, or an evening at the farmers' market. The visibility of Parkdale is different. It is visible as a Neighbourhood Improvement Area with a low "equity score," for example, and a disproportionately high number of "risks" to optimal childhood development. These spaces are produced relative to one another, and relative to emergent norms and ideals across a range of urban governance sites. And just as some lives, bodies, and daily material realities are produced as "outside" the ideal, they also become depicted as a threat to it: disease, decay, decline, and disorder serve as the implicit and explicit "other" against which the spatial and corporeal claims to "clean, green and calm" are staked. The emergent differentiation of Roncesvalles from Parkdale is therefore in no small way about the production of "health" as a corporeal, spatial, biopolitical phenomenon. The identity of Roncesvalles depends on difference and on an otherness that is not only racialized, as Teelucksingh (2002) argues, but also "healthified." Or, perhaps it is more accurate to say that the racialization is bound up with healthism in important ways.

Chapter 6
The Healthification of Parkdale

"Top people live longer."
—R. G. Evans, 1994

"Live Younger, Longer."
—Sukha Spa, 2015

"Toronto is apparently a real power yoga town."
—Anonymous, personal communication, June 2015

1. Introduction

This chapter extends the analyses of the previous chapters by examining how Complementary and Alternative Medicine (CAM) agents and practitioners define their work and their world in Roncesvalles and South Parkdale. In particular, I am interested in how the urban is problematized in relation to health, as well as how CAM practitioners perceive and negotiate the space of the urban milieu in which they work. What kinds of subjects of health are produced in these spatial practices? In what ways do they conform to or contest the types of problematizations of urban space and health that are discussed in previous chapters? To what extent are dominant discourses internalized or challenged? If they are challenged, in what ways?

In addition to the changes associated with gentrification discussed in Chapter 5, the Parkdale/Roncesvalles area has, in recent years, seen the commercial landscape change in ways that privilege different forms of consumption than in the past. In particular, the area has seen a growth of private "holistic" and "alternative" health services and products, commonly referred to as "CAMs."[1] This has brought qualitative as well as quantitative

[1] CAMs are a diverse group of modalities and products; however, the collective noun is appropriate here, as it captures the fact that it is rare in the areas studied to find an organization offering only a single modality, such

changes to the landscape that align with broader shifts towards the responsibilization of health and the promotion of neighbourhood "vitality" as a key objective of urban governance. The surfacing of CAMs in the Parkdale area should be understood as part of the broader trend towards a vital politics of gentrification, of modes of governing self and others. These modes of governing place questions of vitality at their core, and the politics of distinction traced in the previous chapter is a part of this process. To support these claims I show that CAM organizations effectively, if not intentionally, contribute to the healthification (Fusco, 2006, 2007) of Parkdale in three ways. The first is by creating a tangible street-level presence of health and wellness commodities and services. The second is through the modes of governing and subjectively relating to self and others through the "imperative" (Lupton, 1995) to optimize health. The third is through the production of particular spaces as aesthetically healthifying.

The chapter unfolds in three sections. First, I present the evidence of a dramatic street-level institutional realignment beginning in the early 21st century, which privileged a new and healthified form of consumption. I document both a quantitative shift in terms of the growing number of health commodities on offer, and the qualitative changes this brings to the streetscape. Concerning the latter, I highlight the use of naturalist and Orientalist (Said, 1978) discourses and images in the production of healthified space. In the second section, I draw on interviews conducted with CAM practitioners in the Parkdale/Roncesvalles area in the spring and summer of 2015 to assess the kinds of subjectivities produced in and through these practices. In the third and final section, I return to the question of gentrification by considering what I call "the problem of luxury," as CAM providers describe it. In particular, I show how service providers negotiate the challenges of

as yoga, for example, or naturopathy, and this is not unrelated to gentrification pressures. Thus the proliferation of these health and wellness offerings can be understood as part of the gentrification dynamic.

producing space for a commodity, which, in this context, is treated as simultaneously a luxury and a necessity: health.

2. The Emergence of CAMs in the Parkdale Landscape

2.1 The Mainstreaming of CAMs

According to Heather Boon, a leading Canadian biomedically trained scholar of alternative medicine, "CAM is clearly more than a fringe phenomenon, and this dramatic increase in its use over the past 10 years cannot be overlooked by conventional healthcare practitioners, researchers and decision-makers" (Boon et al., 2006, p. 21). Indeed, observers from a range of fields have noted the growing prevalence and popularity of CAMs, as well as political and scientific legitimacy of such therapeutic modalities both in Canada and in other advanced industrial nations such as the US the UK and Australia (Achilles et al. 1999; Barcan, 2011; Eisenberg et al., 1993, 1998; Esmail, 2007; Heelas, 1996, 2008; Health Canada, 2003; National Institutes of Health, 2014; O'Reilly, 2000; Ramsay, 2009; Ross, 2012; Tovey, Easthope & Adams, 2004).

Some see this as a positive development offering patients and health care consumers diversity, pluralism, and greater freedom of choice in health care (Barcan, 2011; Bohnen, 1994; Cant & Sharma, 1999) as CAMs are "mainstreamed" into Canadian society (Canada, 2003; Tovey, Easthope & Adams, 2004). Others, however, see the "renaissance" (Johnston, 2004) of CAMs as bound up with broader political dynamics which construe health as strictly an individual matter, and a "personal moral achievement" (Lavernce & Lozanski, 2014, p. 76; see also Crawford, 1980). Wellness-oriented practices are also increasingly offered in the workplace as employers seek to decrease illness-related absences and optimize

productivity (Herzog et al., 2016; Lavernce & Lozanski, 2012; I #1; I #8; I #9; I #10). As Herzog et al. explain in a recent article in *Administrative Theory and Praxis*:

> If wellness programs and biometric [health risk] testing are successful they can help create utopian or near-perfect employees. Utopian employees are motivated, productive, ethical, satisfied, and committed to their organizations. Nonutopian employees lack motivation, are unproductive, engage in unethical behavior, lack job satisfaction, and do not commit to their organizations, thereby creating a dystopia in the workplace. (2016, p. 40)

Such programs achieve success by offering various "carrots" for employee participation in the optimization of their own health, including prizes; access to specialized, personalized health information; and feelings of subjective motivation and wellness (Herzog et al., 2016).

In addition, the legal status of CAMs has changed in recent decades. In Ontario and Toronto, laws and regulations pertaining to the health professions in the 1990s were changed, in part, to shape patterns of individual health consumption in ways that would contribute to the overall efficiency of the health care system through the encouragement of "consumer choice" and "flexibility" (Achilles et al., 1999; Bohnen, 1994; O'Reilly, 2000). In 1991, the government of Ontario introduced a radically new structure for governing the health professions (Bohnen, 1994; O'Reilly, 2000). Pursuant to a lengthy review of health professions, the government introduced regulation changes to make the development of expertise and professionalism pertaining to health and health care less restrictive, elitist, and male-dominated (Bohnen, 1994; O'Reilly, 2000; Spiers, 1988).

In Toronto in the late 1990s, changes were also introduced to the regulation of some CAM practices at the municipal level. Around the time of amalgamation the existing by-law limiting the number of "body-rub parlors" to 25 citywide came under scrutiny for its apparently unintended effects on certain kinds of "holistic" practitioners. By-law 20-85, which dated to the 1970s, defined "body rub" as

> "the kneading, rubbing, massaging, touching or stimulating, by any means, of a person's body or part thereof but does not include medical or therapeutic treatment given by a person otherwise duly qualified, licensed or registered to do so under law buy the Province of Ontario." (By-law 20-85*,* as cited by Ruddell-Foster, 1998)

This became problematic around the time of amalgamation in the late 1990s, when a proposal was made to introduce a "holistic clinic" license to distinguish between "therapeutic" and "non-therapeutic" forms of massage that were not otherwise regulated by the College of Massage Therapists of Ontario (CMTO) (Achilles et al., 1999; Ruddell-Foster, 1998). The imperative of a new category took shape around a concern that people may be unable to distinguish different types of massage services, given that the main distinction hinged upon the intangible category of "intent" (Ruddell-Foster, 1998). The Council produced a report to address "options for controlling body rub parlors without impacting on the complementary therapy disciplines" (Ruddell-Foster, 1998). One of the major difficulties in this task was defining what exactly a "holistic service" is, and therefore of determining "what is to be regulated, and the requirements for obtaining a holistic services license" (Ruddell-Foster, 1998). Here the problem space was between "body-rub parlors" on the one hand, and, those professions that were already deemed "legitimate" by virtue of their legal recognition and regulation at the provincial level, on the other. In other words, it is about creating a space of legitimacy for particular kinds of human interactions that are virtually indistinguishable, beyond or without consideration of the question of "intent". The holistic clinic-licensing category is therefore interesting in that it does not apply to all clinics that name themselves "holistic" or that understand themselves to be providing "holistic" services. Rather, it applies only to those clinics where a form of massage or "rubbing" is provided by a person not otherwise regulated either by the provincially legislated regulatory body of the CMTO or the municipal body-rub parlor by-law (City of Toronto n.d.-a).

2.2 CAMs in Parkdale

The growing popularity of CAMs relates to shifting governmental logics and truths, which articulate "the Canadian people" as "partners with health professionals in the preservation and enhancement of their vitality" (Lalonde, 1974, p. 6; see also Crawford, 1980). Given the emergent focus on the neighbourhood as the place where people "live, work, and play," and which therefore is a crucial determinant of health, the neighbourhood-level dynamics of the "renaissance" of CAMs is an important dimension which has yet to be explored in the CAM literature.

These broader shifts are discernable in the changing landscape of Parkdale, both in the numbers of CAM products and services on offer, and in the specific discursive strategies used to present these services to the public. Since the late 1980s and in the early 21st century in particular, CAMs have emerged as a "tangible presence in the urban landscape" (Kern, 2012 p. 30)[2] in these areas of West Toronto, and their presence is especially pronounced along Roncesvalles Avenue. As Tables 6.1 and 6.2 (below) show, the emergence of CAMs as a prominent feature of the landscape in Parkdale is a decidedly 21st century phenomenon and is concentrated on and around Roncesvalles Avenue.[3] Within the official boundaries of South Parkdale there are fewer such services than in Roncesvalles, and they tend to have been established more recently. This suggests the emergence of a new dynamic in gentrification.

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[2] Kern (2012) uses this phrase to refer specifically to yoga. My contention is that this is also true, at least in some parts of the city, of CAMs more broadly.

[3] Roncesvalles Avenue and Queen Street are the two main commercially zoned avenues, each with a BIA covering its length. The Roncesvalles Village BIA runs between Dundas Street West in the north and Queen Street in the south. The Parkdale Village BIA runs along Queen Street between Roncesvalles in the west and Dufferin in the east. Note that while the street lengths are similar, in the case of Queen Street both sides of the street (north and south) are predominantly mixed-use with storefronts at ground level and residential rental space above. On Roncesvalles this is true only of the east side of the street. The west side is predominantly residential, though there are proposals currently before the city to change the zoning in the west side to accommodate more mixed use.

Table 6.1 Dates of Establishment of Health Select Health and Wellness Organizations: Roncesvalles

Established	Address	Occupant 2015	Occupant in 2001	Occupant 1995
1988	24 Roncesvalles	Otani Shiatsu Clinic	Otani Shiatsu Clinic	Otani Shiatsu Clinic
1989	47 Roncesvalles	Health From Nature	Health From Nature	Warmia Deli
1990	2333-208 Dundas West	HBS Naturopathic Clinic, Inc.	HBS Naturopathic Clinic, Inc.	N/A
1990	2333-202 Dundas West	Bloorcourt Chiropractic Centre Dr. Memrik	Bloor Naturopathic Clinic	N/A
2000	409 Roncesvalles	The Herbal Dispensary & Community Clinic	Niejadlik Advertising; Ryders Art Supplies	Niejadlik Advertising; Residential
2001	2281 Dundas West	Active Yoga	Residential	Residential
2001	217 Roncesvalles	Qi Natural Foods	Dollar Bargain	High Park National Real Estate
2002	294 Roncesvalles	Sukha Spa	WM Matulak, DDS	WM Matulak, DDS
2003	141 Roncesvalles	All One Holistic Clinic	Canada-Poland Chamber of Commerce; Polimex Trading, Inc.	Polimex Trading Inc.
2004	240 Roncesvalles	Village Healing Center & Bohemian Palace Yoga	Not listed (United Church)	Not listed (United Church)
2005	219A Roncesvalles	Pure Health Wellness Clinic	Qu [sic] Natural Foods	Artistic Beauty Salon
2008	437-105 Roncesvalles	Evolve Complete Chiropractic Care	N/A	N/A
2012	27 Roncesvalles	Village Park Chiropractic Heath Centre	Holistic Medical Centre	Not listed
2012	197 Sorauren	Sama Yoga & Bodywork Studio	Residential	Residential
2013	2238-B105 Dundas West	Damask Studio: Yoga, Pilates & Personal Training	Disability to Function Rehabilitation and Physiotherapy	N/A[1]
2013	2238-215 Dundas West	Wholistic Care Centre	Natural Pain Therapy Centre	Midwife Alliance
2015	99 Roncesvalles	The Village Juicery*	Universal Beauty Salon	Universal Beauty Salon
2016	155 Roncesvalles	Blitz Facial Bar*.	Willard and Devitt	Willard and Devitt

[1] "N/A" indicates that the building which houses the establishment was in in existence at this time; "Not listed" indicates that there is no listing at that address at that time (i.e. it was possibly vacant, or the property had yet to be subdivided to accommodate a new business).

* Both the Village Juicery and Blitz Facial Bar are Toronto-based wellness industry chains with multiple locations across the city, and both have recently expanded into the Roncesvalles neighbourhood. Thus, the anxieties of smaller, non-franchised organizations over the ways in which gentrification and the rent gap will continue to shape the street are not unfounded (pp. 302-305 herein for a discussion).

Table 6.2 Dates of Establishment of Select Health and Wellness Organizations: South Parkdale

Established	Address	Occupant 2015	Occupant in 2001	Occupant 1995
2000	1206 King West	Kings Physiotherapy Clinic	Not listed	Not listed[5]
2005	74 Fraser	The Performance Health Center	IPR Planning and Research; Modem Media	N/A
2007	1344 Queen West	The Well of Alternative Medicine	Financial Stop; H&R Block	H&R Block, Canada; Residential
2008	1382 Queen West	JR's Natural Health and Bulk	Empire Bulk Foods	CNP Super Saving Clothing
2008	131 Jefferson Avenue	The King Liberty Health Centre	Not listed	N/A
2009	1273 Queen West	Parkdale Prana Room	Pygmaliar & Galatea Artisans; Tony's Furniture & Stained Glass	Tony's Furniture & Stained Glass
2011	47 Fraser	Tula South Yoga Studio	Parkdale Community Health Centre	N/A

[5] "N/A" indicates that the building which houses the establishment was in in existence at this time; "Not listed" indicates that there is no listing at that address at that time (i.e. it was possibly vacant, or the property had yet to be subdivided to accommodate a new business).

Table 6.3 CAM Hubs, Number and Type of Practitioners & Services in Select Establishments[6]

Name and Location	Number of Practitioners	Services
The Herbal Clinic and Dispensary, 409 Roncesvalles	Seven therapists	Therapeutic offerings: six, including naturopathy, acupuncture, traditional Chinese medicine, and RMT. A community acupuncture clinic is run part-time out of the practitioner's clinic. Other offerings: yoga classes and free lectures on health-related topics sometimes offered, including herb/medicine walks in High Park. There is also an herbal medicine retail/wholesale business in the same space.
Sukha Spa, 294 Roncesvalles	Five: four therapists; one esthetician	Therapeutic offerings: four, including RMT, reflexology, acupuncture, and traditional Chinese medicine. Both RMT and acupuncture services offered for pregnant women, including pre- and pot-natal services. Other offerings: steam bath and oxygen treatments, a "core detox" program, and retail sales of cosmetic products.
Yoga Village/Village Healing Centre, 240 Roncesvalles	Forty-Six: 33 therapists; 12 yoga instructors; one Qi Gong instructor	Therapeutic offerings: 20 healing practices listed under "healing services," including acupuncture, Ayurveda, naturopathy, reiki, and RMT; 27 varieties of counseling services listed under "counseling," including art therapy, life coaching, registered psychologists, and spiritual counseling. Yoga: daily classes offered on a pay-what-you-choose basis
Octopus Garden Holistic Yoga Centre, 967 College	Thirty-Seven: 14 therapists; 23 yoga instructors	Therapeutic offerings: 12 varieties including acupuncture, chiropractic, naturopathy, psychotherapy, RMT, shiatsu. Yoga: classes, workshops, teacher training, family yoga, yoga in the workplace, yoga clothing. Other offerings: salad and juice bar on site and special events such as community potlucks, Ticketed NY Eve classes sometimes held.
The Well: of Alternative Medicine, 1344 Queen West	Eleven therapists, mostly RMTs	Therapeutic offerings: 4 varieties: RMT, chiropractic, osteopathy, acupuncture. Other offerings: infrared sauna and small shop with health care products and assistive devices.
Parkdale Prana Room, 1273A Queen West	Four: two therapists; two yoga instructors	Therapeutic offerings: six, including two types of gestalt psychotherapy for individuals and groups; meditation, Tai Chi, Qi Gong and Reiki for individuals and groups.

[6] Information as listed on the respective websites, as of March 2016.

The late 1980s marked an important shift in the streetscape of services. In 1988 Otani, a Shiatsu massage therapy organization, opened its doors in a small suburban drive-up plaza at the south end of Roncesvalles Avenue. The following year an MD trained in Poland established Health From Nature (Figure 6.1, below), a natural health products store, as a stand-alone store front across the street from Otani. Otani and Health From Nature represented a new type of health service appearing in the midst of more mainstream health institutions at the South end of Roncesvalles, such as the Copernicus Retirement Lodge, the Sunnyside Medical Arts building, and St. Joseph's Hospital. In the case of Health From Nature, the large flower mural covering its south-facing window also represents the emergence of a significant departure from the more clinical aesthetic of the surrounding establishments.

Figure 6.1 "health from nature." (Photo by author, 11. 25. 2012).

By the 21st century, this new type of alternative health service and the changed ethopolitical (Rose, 2001) aesthetic that it brought with it had become an increasingly important aspect of the commercial landscape. To illustrate this, Map 2 (below) gives a snapshot of the number and distribution of CAMs within the official boundaries of South

Parkdale and Roncesvalles as of January 2013. From this map we can see that there is a cluster of CAM services near the middle of Roncesvalles Avenue, as well as smaller clusters at the south end of the street and another cluster just north of Roncesvalles Avenue on Dundas West, between Roncesvalles and Bloor Street. Tables 6.1 and 6.2 (above) compliment this map by documenting the dates of establishment of the locations depicted on Map 2, thereby shedding light on the temporal dimensions of this distribution of services. Furthermore, Table 6.3 (above) adds to the overall picture by showing the scale and multiplicity of services available at a single address or "point" on the map.

Looking first at Table 6.1 (above), which documents the dates of establishment of currently existing CAM organizations within the boundaries of the official neighbourhood of Roncesvalles, we see that in the 1990s there was a small amount of growth in CAMs in this area. However, in the 21st century CAMs began to emerge as a significant feature of the commercial landscape. According to Table 6.1, of the 18 CAM organizations that currently exist in Roncesvalles, 14 have been established since the year 2000. Moreover, the organizations established earlier (that is, prior to 2000) tend to be located near the "edges" of Roncesvalles Avenue, in medical offices on Dundas (#'s 2238 & 2333), just north of Roncesvalles, or at the south end, where Otani (24 Roncesvalles) and Health by Nature (47 Roncesvalles) are located. The emergence of these kinds of organizations in the more central part of the Roncesvalles strip also suggests a migration out of the medical arts-type building and into the "street-level" shopping area. This is an important shift, both because many practitioners interviewed for this study indicated the importance of walk by traffic (I #4; I #8; I #9; I #10), and because it appears to have implications for the organization of services.

Map 2b. The locations of Alternative Therapies and Natural Health Specialty Stores in Roncesvalles.
Source: "Contains public sector Datasets made available under the City of Toronto's Open Data Licence v2.0." 2011.

Map 6.1 Locations of CAMs in South Parkdale and Roncesvalles (Source: Parish and Schuman, 2011)

Turning to South Parkdale, as Map 6.1 shows, as of 2013, there are significantly fewer CAM organizations within the boundaries of South Parkdale than Roncesvalles. Similarly, looking at Table 6.2, which shows the dates of establishment of existing CAM organizations within South Parkdale, we see that their emergence is a more recent phenomenon, since all of them have been established since the year 2000. Of further note is that the majority of the establishments in South Parkdale are in the Liberty Village BIA area of Parkdale. This is significant because Liberty Village has been a site of intensive condominium development, as well as a bourgeoning hub for IT companies, since the early 1990s (Wieditz, 2007). The area was formerly zoned as industrial and was the site of much of the industrial employment in the neighbourhood from the 1800s to the post-WWII period. By the early 1990s, the last industrial buildings in the area were abandoned and became home to a growing number of artists who valued the large spaces as affordable places to establish live-work type residences (Wieditz, 2007). However, in the mid-1990s deregulation and rezoning in the area made it an attractive area for redevelopment by commercial and residential property development companies (Kern, 2010; Wieditz, 2007). Today, this part of the neighbourhood, with its new steel and glass towers and "creative class" industries, and condos stands in marked contrast to the socio-economic marginalization of the rest of South Parkdale (Boudreau, Keil, & Young, 2009, pp. 190-191; Kern, 2010).

Furthermore, in the new building spaces in both official neighbourhoods, health services appear prominently. For example, in the High Park Lofts, built in 2007[7], there is a multidisciplinary clinic called Evolve Chiropractic, which offers chiropractic, naturopathic, and

[7] This site was formerly home to a church, a market, and a Kentucky Fried Chicken (Kern, 2010, p. 198). Kern writes of her experience snapping pictures of the "doomed landmarks": "as I raise my camera a well dressed blonde woman in her thirties walks past the buildings. She stops and turns around, walks up to the door of the market, and reads the ad for the lofts, which start at around $200,000. What she does not see – what few see – is the homeless men who sleep in that doorway at night" (p. 198). Ten years later the latest condo development around the corner will start in the "low $300,000s." The presence of urban homelessness is increasingly invisible, and/or normal and no longer shocking in this area with its private security guards and vestibules locked at night.

massage therapy services. Similarly, in Liberty Village, virtually every new and re-purposed building and plaza has a yoga studio, a natural health food store, or more commonly, a multidisciplinary health and wellness space, such as the Performance Health Center at 74 Frazer Street.[8]

2.3 The Healthification of the Landscape

These quantitative changes have accompanied the qualitative changes, characterized by three aspects. First, there is a discernable shift away from working-class and ethnic-oriented (i.e. Polish/Eastern European) services, and towards luxury and boutique-style offerings. Second, as new storefront space becomes available, CAM organizations increasingly occupy such space at the street level, and are no longer hidden away as a minority presence in multi-story medical arts buildings such as those found at the north and south ends of Roncesvalles Avenue. This new presence contributes to the healthification (Fusco, 2006) of the neighbourhood space, rendering the "imperative of health" (Lupton, 1995) a tangible aspect of the experience of this urban landscape. Third, the street-level presence of CAMs contributes to and plays upon a naturalist and at times Orientalist (Said, 1978) aesthetic sensibility.

Looking at Tables 6.1 and 6.2 we can see that CAM establishments replace ethnic-oriented and working-class shops and services such as used furniture shops and used clothing stores, an H&R Block, the Polish Chamber of commerce, a discount hair salon, a bulk food store, and a dollar store. For example, on Roncesvalles, Qi Natural Foods, a specialty food store offering a selection of natural and organic foods, cosmetics, and household items, has replaced the Dollar Bargain store. The Polish Chamber of Commerce and Niejadlik Advertising have been replaced by All One Holistic Clinic and The Herbal Dispensary and Community Clinic, respectively (see Table 6.3 above for a detailed breakdown of the CAM offerings

[8] The western portion of Liberty Village falls within the official boundaries of South Parkdale and Ward 14. There are several additional clinics located just outside of these boundaries in Liberty Village.

available at these addresses). The emergence of organic grocery stores and juice bars has been discussed in the literature that highlights the classed, gendered, and racialized politics of producing the self as an "ethical" and "reflexive" consumer through proper food choices (Guthman, 2003; Hadsell, 2016; Kern, 2012; Power, 2016; Sharzer, 2010; Zukin, 2008). For example, Power (2016) argues that Whole Foods Market, an Austin, Texas-based "natural foods" chain with locations in the US, the UK, and Canada,

> can be seen as the paradigmatic example of the shift that Crawford [1980, 2006] identifies in which concerns about health and the environment moved out of the collective public realm into the private, individualized arena of the market, where profits can be made by trading on consumers' desires and anxieties…. By encouraging health through virtuous consumption, Whole Foods Market thus offers its customers the opportunity to consume with distinction, markedly different than the "culinary mainstream marked by fast-food and generic mass market foods associated with ill health, poverty and obesity." (Power, 2016, pp. 56-57, citing Johnston)

Similarly, Qi Natural Food, the Herbal Dispensary & Community Clinic, and All One Holistic Clinic are part of a broader dynamic whereby stories catering to the tastes of more affluent customers displace stores and services catering to working-class people (Glass, 1964; Hyde, 2017; Zukin et al., 2009). This more affluent group are looking for "local" and organic foods (Polzer, 2016; Kern, 2012), as well as "green" household products (Hadsell, 2016) and health and beauty services that do not appear to conform to the "rationalization of the body and emotions in contemporary society" (Reddy, 2004).

Moreover, even when CAMs take the place of other health services, there is a shift in the substance of the offerings as well as in their discursive presentation. For example, around the year 2002 the Sanskrit-named "Sukha Spa" (Figure 6.2, below), replaced the practice of W. Matulak, DDS [Doctor of Dental Surgery] practicing on Roncesvalles. Sukha offers a range of services, including massage therapy, acupuncture, and facial treatments (see Table 6.3) in a luxury day-spa environment. Similarly, the address of the pragmatically named Disability to Function Rehabilitation & Physiotherapy is now the home of the exotically named Damask

Studios. Damask offers yoga, pilates, and fitness classes, as well as the services of a naturopathic doctor. Both of these newer establishments lay claim to "the East" in naming and other discursive strategies. For example, Sukha includes the Sanskrit rendering of its name on its signage, which, as the website explains, translates to "a state of happiness from within" (Sukha Spa, 2015). Similarly, Damask invokes a reference to a type of weaving and a style of tapestry produced in, and traded through, Damascus on the Silk Road.

Figure 6.2 "Live Younger, Longer"[9] (Photo by author 12.18.2012)

Secondly, the imperative of health becomes tangible in the healthification of the landscape. Fusco (2007) defined healthification as "the continuous deployment of a broad range of specialized techniques and technologies… that work together to produce 'healthified' spaces (and subjectivities)" (p. 59). Such measures may include "policy and educational initiatives, architectural arrangements, urban planning, measures of public order, health and safety regulations, self and other observations" (Fusco, 2007, p. 59). On Roncesvalles Avenue, the Polish bakeries and delis established by first-generation immigrants are closing down as costs

[9] Note the lotus flower on the sign in the background.

rise, profit margins fall, and the tastes of consumers change (Mejia, 2011).[10] As that happens, new storefront space becomes available, and increasingly, CAM organizations take their place as street-level, storefront shops and "boutiques." This has the effect of visibly altering the streetscape, such that the presence of an array of therapeutic offerings has become an integral part of the shopping district and the shopping experience. This quantitative shift towards a growing number of organizations offering CAM therapies, as well as health food stores and juice bars, has the effect of emphasizing the imperative of health, and of the individualized and consumption-based work of optimizing health.

In addition, the grammatical use of the imperative case in CAM business naming and branding practices in general, and in Roncesvalles in particular, accentuates the healthification of the landscape. In her critique of the New Public Health, Deborah Lupton (1995) argues that health has become an *imperative:* something that one must work on continuously in order to be a normatively "good citizen." In this context, Lavernce and Lozanski (2014) highlight the significance of moral injunctions to the branding strategy of lululemon athletica:

> The primary source of advertising has been the printing of "the lululemon manifesto" onto their red and white reusable bags. The manifesto, which provides the company's corporate and philosophical vision, includes a series of one-line prescriptions that map out the brand identity through appeals to self-betterment: "breathe deeply", "do one thing a day that scares you" and "this is not your practice life." (Lavernce & Lozanski, 2014, p. 77, citing lululemon athletica)

A similar phenomenon is discernable on Roncesvalles Avenue. For example, the business name Health From Nature is both a description and a command: it informs us that there are "natural" remedies being sold, but it also commands us to be healthy through a relationship with "nature." Similarly, Sukha Spa (284 Roncesvalles) includes the tag line "live

[10] "[W]e've noticed that desserts aren't as popular as they once were" says Elizabeth Klodas of her families' decision to close Granowska's Bakery after 39 years on Roncesvalles (cited in Mejia, 2011).

younger, longer" on its exterior signage, website, and business cards (see Figure 6.2, above). This particular directive is interesting for the way in which it echoes, whether intentionally or not, Lalonde's framing of the central objective of the New Public Health, to "add years to our life and life to our years" (Lalonde, 1974, p. 6). The name Evolve Chiropractic (304 Roncesvalles) suggests both biological determinism and a duty to "civilization": you must evolve. This latter business name-cum-lifestyle directive is also reminiscent of the meme "Progress of Man," which has recently been appropriated by various organizations to claim yoga as the latest and highest stage of "evolution." Figure 6.3 (below), taken from a T-shirt produced by the US-based Spreadshirt company, shows an explicitly gendered version of this meme wherein a career woman is superseded by a woman in Natarajasana, or "lord of the dance pose" (*Yoga Journal*, 2017).[11]

Figure 6.3 Progress of "Man" (Source: Spreadshirt, 2016). © Dale Keele, 2008. Reproduced with permission.

Finally, there is the product line of the Village Juicery (Figure 6.4, below), which opened its doors at 99 on Roncesvalles in 2015. The Village Juicery is a local Toronto chain that

[11] For a sampling of other popular versions, see https://www.spreadshirt.com/center+evolution+yoga+t-shirts.

produces and sells "organic, never HPP'd [high pressure pascalized or processed] cold pressed juices" that are "designed by nutritionists" (Village Juicery, 2016). In fact, as a key strategy of distinction from myriad other juice bars that have recently spread across the city (Ipsum, 2015), the Village Juicery boasts that a registered nutritionist is always on hand in their locations to advise on juice purchases as well as wellness programs offered by the organization. The Village Juicery organizes its entire product line around the imperative to "be": "Be Green," "Be Clean," "Be Active," and "Be Calm," for example (Village Juicery, 2016).

Figure 6.4 "Be Clean, Green, Calm" etc. (Source: Village Juicery, 2016. Reproduced with permission.)

2.4 Nature, Orientalism, and "Other" Spaces for Capitalist Urbanism

In many instances, these changes have been bound up with a naturalist and Orientalist aesthetic. On Roncesvalles Avenue, in particular, the importance of "nature" has accompanied the imperative of health. These changes included the introduction of a new aesthetic of health as "natural" and distinct from the bureaucratic functionalism associated with biomedicine. Today this aesthetic is more widely dispersed in the area. Similarly, the use of Orientalist tropes to produce spaces that are "Other" to the time-space of capitalist urbanism is apparent in many of these names, phrases, and images.

Literary critic and theorist Edward Said coined the term *Orientalism* in his classic work, published in 1978. Said named and described the process through which the "the Orient" and "the Occident" are produced in relation to one another, in a "man-made" geography and set of ideas. For Said, this particular geographic imagination is crucial to how people and places of the "East" were domesticated for European consumption. For Said, modern Orientalism refers to a form of expert knowledge emanating from the 19th century academic disciplines of philology, history, and anthropology, and their application to the study of people and places geographically "East" of the Christian West. However, far from "being an exclusively intellectual or theoretical" enterprise, "Orientalism fatally tend[s] towards the systematic accumulation of human beings and territories" (1978, p. 3). Orientalism is thus a particular mode of organizing racialized and gendered knowledge-power: "in short, Orientalism is a Western style for dominating, restructuring, and having authority over the Orient" (p. 3), which dates to the 18th and especially 19th century imperial practices. Fundamentally, the concept of Orientalism describes a European way of imagining, speaking, and writing about the Orient in a way that presumes familiarity and therefore authority, power, and worldliness: "The modern [i.e. 19th century] Orientalist was, in his view, a hero rescuing the Orient form the obscurity,

alienation, and strangeness which he himself had properly distinguished" (1978, p. 121). This is a particular kind of knowledge-power—"power to have resurrected, indeed created the Orient"—with its own spatial and temporal techniques. "In short having transported the Orient into modernity the Orientalist could celebrate his method, and his position as that of a secular creator, a man who made new worlds as god had once made the old" (Said, 1978, p. 121).

Some CAM scholars (Harrington, 2008; Klassen, 2011; Lavernce & Lozanski, 2014; Reddy, 2004) have taken up the question of contemporary forms of Orientalism evident in the North American enthusiasm for "Eastern" medicine and healing practices, such as Chinese medicine and yoga. Some see the popularity of yoga as depending on its capacity to draw on longstanding Orientalist tropes that continue to have the power and salience to be rich sources of subjectiviation of the race- and class-privileged (Lavernce & Lozanski, 2014; Reddy, 2004). Others see the contemporary desire for the "East" as taking shape on rather different terms, which are symptomatic of growing tolerance and multiculturalism in liberal societies (Harrington, 2008; Klassen, 2011).

In her genealogy of mind-body medicine, historian of science Anne Harrington (2008) identifies several key narratives that organize discourses around mind-body healing. Two of these are most pertinent to our interest here. The first she calls the "broken by modern life" narrative. Foundational to this narrative is the importation of the notion of "stress" from metallurgy to physiology, circa 1970. This new notion of stress came to compliment longstanding discourses and ideas pertaining to the deleterious effects of modernity and urban life on the body, mind, and soul. Harrington argues that another narrative, which she calls "Eastward journeys," emerged as a neo-Orientalist "balm" or antidote to the diagnosis offered in "broken by modern life." For Harrington, this neo-Orientalism entailed a "moral inversion"

relative to older forms of Orientalism, which historically played a key role in "advancing European colonialist and imperialist agendas" (p. 208).

> Orientalist conventions of writing and thinking were also used in the United States and Europe by critics and radicals who effectively reversed the original moral logic of this tradition. Still stylized, still exoticizing, this new, more romantic form of Orientalism used idealized images of the East to highlight Western moral and spiritual failings…. By the second half of the twentieth century, as colonialism became a shameful legacy and Western cultures continued to grow more ambivalent about their modern values and lifestyles the romantic variant of Orientalism – an Orientalism dominated by visions of ancient teachers, texts filled with occult secrets, meditating monks on misty mountain tops and serene sanctuaries – gained a new lease on life, especially within alternative counter cultural circles. (p. 208)

Importantly, within the late 20th century "Eastward Journeys" narrative, the "East" is "not only a spiritually, but also a medically exemplary place" (Harrington, 2008, p. 208).

Likewise, in her study of the marketing to US consumers of products associated with the traditional Indian medicine system of Ayurveda, communications scholar Sita Reddy identified five groups of target consumers. These included a "general middle class audience"; a more conservative middle class of entrepreneurs with an interest in "sacred commerce and prosperity consciousness"; women desiring enhanced beauty through the use of "natural" products; and "educated liberal environmentalists… looking towards the East for an antidote to Western materialism and the stress created by capitalist life" (2004, p. 217). For the latter group Ayurveda is "a haven, an island of gentle breezes and calm sanity in this world of increasing violence, chaos and overmedication" (p. 219, citing *New Times*). The agents of the British Empire once set out to "save" Eastern subjects through Christianization, but today, "vague, homogenizing and orientalist concepts of Eastern spiritualties" (Lavernce & Lozanski, 2014, p. 76) are increasingly positioned has holding the potential to "save" the stressed-out subject of "Western" capitalism and even to "elevate the world" (lululemon CEO, Christine Day, cited in Lavernce & Lozanski, 2014 p. 77).

Consider, for example, the contrast between the aesthetic strategies of two businesses that offer different types of therapeutic massage. Otani Shiatsu Clinic was one of the first, if not the first, "alternative" health providers on Roncesvalles. Today this organization is somewhat exceptional, both for the absence of an obvious emphasis on nature, trees, and green consumption, and for the absence of a "luxury theme" that is now prevalent within CAM organizations. The remarks of one Yelp reviewer are particularly instructive in highlighting how this establishment differs from the new mainstream in CAM. The reviewer writes: "No frills and the price is right. The owner is Japanese as are many of the masseurs. Think old school 70s Japan Ma & Pa shop... no Zen theme luxury decorator touches. A Roncesvalles staple for at least 15 years or more" (Meems C., 2012).[12] In other words, this reviewer appears to be recommending the establishment based on the *absence* of Orientalist techniques, coded as "Zen theme luxury décor touches," for producing a therapeutic experience, as well as the perception that such techniques lead to a higher price tag for services.[13]

This stands in marked contrast to Sukha Spa, which actively cultivates a luxurified, naturalist and Orientalist aesthetic by using a Sanskrit word as its name and including Sanskrit text and a hand-drawn lotus flower on its signage. Sukha further emphasizes its location in the "heart" of Roncesvalles village, and, perhaps therefore, a safe distance from its more working-class edges:

> Sukha Spa is a boutique spa located in the heart of Roncesvalles Village in Toronto, Canada. The spa operates in an Edwardian home built in the late 1800s. Our atmosphere is relaxed, warm and inviting. Sukha Spa prides itself on being a safe haven for our clients. We offer a unique, personal and caring experience to each of our guests.

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[12] Review found at http://www.yelp.ca/biz/otani-shiatsu-clinic-toronto.

[13] As of March 6, 2016, a one-hour treatment at Otani was $65 plus HST. See http://www.otanishiatsuclinic.com/rates.html. Compare with Sukha where a one-hour massage costs $90 plus HST. See http://sukhaspa.ca/rmt/.

> Enjoy your Sukha experience, we look forward to welcoming you. Live Younger, Longer. (Sukha Spa, 2015)[14]

These references to "a relaxed warm and inviting" environment and a "safe haven" construct the space as a therapeutic retreat (Little, 2013) from the hectic pace of urban capitalist life; and the Orientalist tropes serve to underline the "otherness" of the time-space of the spa relative to its broader environment. This "othering" presents itself as unproblematic, and even "good," in ways that are consistent with the moral inversion described by Harrington. However, evidence of the harsh realities of capitalism presumably includes the slow erasure (Kern, 2015b) of the neighbourhood's former identity as a working-class Polish area with a local industrial employment base. The references to safety and care also serve to affirm that Sukha is the right kind of spa, one where "therapeutic" benefits can be sought and obtained.

This contrast suggests that there is nothing inevitable about the use of an Orientalist motif in CAM organizations, whether or not the proprietors happen to be migrants from the East. Furthermore, it reasonable to speculate that the aesthetic contrast between Otani Shiatsu, which was described as not having "Zen theme luxury décor," and Sukah, which actively cultivates an Orientalist and luxurified aesthetic, has as much to do with racialization as it does class. Shiatsu is in a somewhat unique legal situation in Toronto, as it is a form of massage that is not regulated by the College of Massage Therapists of Ontario. Unlike many other self-described "holistic" practitioners in the new wellness industries, Shiatsu practitioners therefore require a "holistic clinic license". Given that the birth of the licensing category of "holistic clinics" is tied to the effort to make a legal distinction between sexual and non-sexual massage, the preference for a "clinical" aesthetic over "luxury décor" could be read as a strategy for resisting racist associations between Asian women, massage, and sex work.

[14] See also Sukha Spa website. http://sukhaspa.ca

These uses of Orientalism and nature mark CAM organizations as "Other" time-spaces to the daily rigours of urban capitalist life. Practitioners emphasize both the critical importance of stress and the need to take time out to recuperate, as they position themselves both as specialized health professionals and as therapeutic practitioners capable of addressing the malaise of capitalist urbanism, more broadly. In order to fulfill these roles, it is therefore necessary for practitioners to be able to offer not just a healthy or healthified *space* for the unfolding of the therapeutic relationship; it is also necessary to produce a temporality conducive to this experience. The emphasis that is so prevalent in CAM discourse (especially in yoga) on making a connection to something more natural, whether in the world or in oneself, derives much of its legitimacy and authority from the assumption that there is a disconnection that can be "healed" or reconciled through certain kinds of bodily practices and through a particular kind of health consumption.

What these spatio-temporal dynamics amount to is a sustained effort to produce, in a material sense, a "natural" world that extends from the interior arrangement of the CAM organization to the exterior world of the streetscape. The production of this heterotopic "Other space" (Foucault, 1984) to capitalist urbanism relies in important ways on Orientalist tropes to produce a spatial and temporal experience which is different, and therefore an escape from, the space and the temporality of capitalist urbanism. The effect, if not the intent, is the appropriation of an entire life world for urban capitalist production and social reproduction. While this is often presented as a technique of diversity, or at least as practices which conform to broader governmental consensus around the importance of diversity in a globally competitive economy (Abu-Laban & Gabriel, 2002; Blomley, 2004; Valverde, 2012), I show how these processes are also bound up with a homogenization of ways of living and being in the world.

This is especially significant in light of Kern's (2015b) recent work on the temporality of gentrification. Roncesvalles in many ways conforms to the ideal of an "eventful" and "happening" neighbourhood identified by Kern. For example, it has a weekly farmers market and annual street festivals such as "Roncy Rocks" and the Roncesvalles Polish Festival (Roncesvalles Village BIA, 2016). However, this other dynamic, that of slowing down, "pampering," and taking time out to "recuperate" (Little, 2013), is also important, and raises similar questions about who can participate. This aspect of time is also related in important ways to the naturalist (Crawford, 1980; Lea, 2008; Little, 2013) and Orientalist (Said, 1978) tendencies within CAMs (Harrington, 2010; Lavernce & Lozanski, 2014; Reddy, 2004).

Foucault used the term heterotopia to name the spaces that are produced in order to be Other, or counter to, the dominant order of society. Heterotopias are different from utopias because "utopias are sites with no real place" (1984, p. 3). Utopias are "sites that have a general relation of direct or inverted analogy with the real space of society. They present society itself in a perfected form, or else society turned upside down, but in any case these utopias are fundamentally unreal spaces" (p. 3). At the same time, however, there are real sites that reflect society back onto itself:

> There are also, probably in every culture, in every civilization, real places—places that do exist and that are formed in the very founding of society— which are something like counter-sites, a kind of effectively enacted utopia in which the real sites, all the other real sites that can be found within the culture, are simultaneously represented, contested, and inverted. Places of this kind are outside of all places, even though it may be possible to indicate their location in reality. Because these places are absolutely different from all the sites that they reflect and speak about, I shall call them, by way of contrast to utopias, heterotopias. (Foucault, 1984, p. 3-4)

Foucault argued that historically there were two main types of heterotopia—heterotopias of crisis and heterotopias of deviance—but that in the 20th century these two typologies were becoming less and less distinguishable from one another. I submit that the

distinctiveness of the spaces produced for the therapeutic encounter and experience can be understood as a heterotopia of crisis and normalization.

3. What is Health?

"That's a big question! OK where do I start? Balance, everything is in balance." (I# 11)

"My view on health and wellbeing is that it's constant work and application."

(I# 1)

"Health and wellbeing, what do I think about it? That I don't practice it enough." (I# 9)

"The people that I help are people who are interested in their own health. They want to take responsibility for it. I want to actually live in a society where we take more personal and individual responsibility." (I# 5)

Me: What are people mostly coming to see you for? Do you have a set of services or complaints that people are mostly..?
I# 7: Yes: digestive, thyroid, hormones, *stress*, anxiety, depression… are you getting this a lot?
Me: Yeah. (1# 7, emphasis in original).

3.1 Health Promotion and Life Optimization

Scholars critical of "healthism" have pointed to the individualizing, responsibilizing, and medicalizing dimensions of CAMs, and holistic medicine in particular (Crawford, 1980; Lavernce & Lozanski, 2014; Lowenberg & Davis, 1994), and to the New Public Health emphasis on optimization in general (Chödrön, 2015; Crawford, 1908; Fusco, 2006, 2007; Metzl, 2010; Murray, 2015; Polzer & Power, 2016). The idea that health is something that requires commitment, responsibility, and "constant work and application" is emphasized in the quotes presented at the beginning of this chapter. These quotes echo the language of the optimization of health that now riddles that landscape on Roncesvalles Avenue, and to a lesser extent, Queen Street West.

Health and wellness professionals interviewed for this project offered many reflections that are of interest in light of the broader political dynamics that are at play. In the interviews practitioners offered specific examples of health issues related to stress, such as digestive issues, trouble sleeping, or pain and its management, but many also spoke of stress in a more general way as a kind of condition of alienation in the face of the hectic pace of modern life. Here alienation could take the form of alienation from oneself, one's body, or from the natural world, or an inability to take time out for the care of the self. Accordingly, practitioners frequently discussed stress and the need to take time out—or, as one respondent put it, to "press pause"—in their discussions of what makes people well or unwell, healthy or unhealthy. In this way, health and wellness providers positioned themselves both as professionals treating specific complaints and as experts providing more generalized solutions to the stress of urban capitalist life.

I asked all interview participants to talk about what the concepts of health and wellbeing meant to them, and conversely, what ill health meant, as well as whether or how they felt that health-related attitudes and practices were changing. As the quotes above demonstrate, many practitioners raised themes familiar to health-promotion discourse: prevention, lifestyle management, and stress reduction. Many also used the language of optimization and the related ideas of responsibilization, or of health as "constant work and application." Additionally, most participants talked extensively about stress and the ability to cope with life's challenges. Many offered an analysis of health that was related to notions of balance, connection, and awareness. What they specifically meant by this varied somewhat, but often notions of mind-body balance, as well as mind-body-spirit balance, were discussed. In stressing the need for balance, time to recuperate, and the need to take time out from the hectic pace of modern life, these practitioners echoed what historian of science Anne Harrington (2008) called the "broken by

modern life" narrative of mind-body medicine. In this narrative, forms of health and wellness practice are seen as therapeutic solutions to the malaise of modern life. In her research into spa culture in rural England, Jo Little showed how the act of "retreating to nature" (Lea, 2008) was part of the social reproduction of the middle-class female self. Taking time out for the self, she argued, is what women juggling the responsibilities of work and family life do, as part of the process of being able to "get up and do it all over again tomorrow" (Berlant, 2010). This is important because it raises the question of who can escape, who can put some of the pieces back together, and in what ways.

The informants discussed and quoted below drew heavily on the language of the New Public Health in describing what they do as professionals and how this relates to the publically insured system.[15] Recall that Lalonde (1974) argued that the conventional health care system had become a disease maintenance system, and needed to be reoriented towards the goals of prevention and promotion. Further, he argued that the work of promoting health and preventing disease was properly located outside of the formal health care system, "beyond health care," and in the realms of genetics, environment, and lifestyle.

> Our job is health promotion. It's life optimization. The conventional system is disease management, and emergency management. That's what they do and that's what they do very well. If you are in a crisis, if you've got kidney failure, you need to be conventionally monitored. (I #1, personal communication, March 28, 2015)

> It's all about stress reduction. So whatever reduces the stress reduces the illness. And if you're reducing illness then you're reducing health care costs, or disease maintenance costs or whatever you want to call it that the system really is. (I #8, personal communication, July 15, 2015)

> I'm teaching every single person the basics of diet and lifestyle. What's the best way to take care of yourself. Because sometimes I take it for granted and I forget that people don't know to sleep with their lights off. So I teach them bedtime hygiene. (I #11, personal communication, July 24, 2015)

[15] To protect the anonymity of these informants, I refer to them using a system for numbering their interviews (e.g., I #1, I #2, etc.). In addition, rather than using gender-specific pronouns, I rely on the non-gendered plural "they" and "their."

These informants explicitly used the health-promotion language in which there is a distinction between conventional care as a "disease management system," and their respective disciplines as health-promotion disciplines, which operate in the spaces and times between needing crisis care. They put a heavy emphasis on individual health and lifestyle counseling, as something that permeates the time of life between moments of "crisis" or "disease." They also clearly see themselves as doing something that the "conventional" or "Western" care system could not or did not do. Thus, while not positioning themselves "beyond" health care, they certainly saw themselves as filling the prevention and promotion gaps that the mainstream system is less apt to take care of.

One practitioner spoke at length about health as a personal financial investment, and something for which self-employed people such as themselves should be saving. Importantly, this informant also indicated that they had been invited on several occasions to speak on this subject to audiences of corporate employees.

> Many CAM practitioners don't have extended health care benefits especially if we are self-employed. I have never had them. So one thing that I do and that I encourage others to do is to put money towards that. I believe in my health and so I assign myself a dollar value at the beginning of the year. For example, if I think that my health care is going to be somewhere between five to seven thousand dollars that particular year, then I'll take that amount away from my income and put it into a different account. Then I'll use that money if I want to go for a massage, or to see a chiropractor, or an osteopath, or a naturopath. Or even if I want to go for a facial. Anyone of those things could fit into what I believe is health and wellbeing. (I #9, personal communication, July 22, 2015)

This speaker emphasizes themes of commitment, discipline, and value: one needs to be disciplined to take measures to provide for one's own health optimization, especially if one does not have employer-sponsored extended health benefits.

3.2 Stress, Capitalism, and Crisis

The theme of "crisis" and the temporality of crisis and care were recurrent in the interviews I conducted. Importantly, whereas for some CAM practitioners, like the naturopath cited above (1 #1), crisis care, which is associated with conditions such as a stroke, heart, or liver failure, is the clear realm of expertise of mainstream medicine, and alternative medicine is much better at on-going care, health promotion, and "life optimization." However, for other CAM practitioners the fact of being "in crisis" was central to what brought people to alternative modalities.

Another informant, a Traditional Chinese medicine practitioner and acupuncturist, described this temporality of care while also distinguishing between "East/West" lines:

> When you are having a heart attack, I am going to call 911. And then I'm going to squeeze your fingertips. But I'll call 911 first, because in the case of a heart attack, Western Medicine is going to be the thing that saves *your life*. And that's ultimately the goal: to save your life. But that one moment where Western medicine can save your life is just that one moment. I can do it until the end of time, until the end of the full life that you've lived, as a Chinese medicine practitioner. (I #5, personal communication, June 10, 2015, emphasis in original)

For this informant Western medicine provides crisis intervention, understood in terms of a major health event such as a heart attack. By contrast, Chinese medicine is the medicine that can bring people to the "end of the full life that you've lived," not by intervening in a moment of crisis, but through ongoing maintenance. This person saw Chinese medicine as life-saving in a different way than "Western medicine," in the sense that it is *life extending*.

Another informant raised similar themes of "East/West difference," while also suggesting a certain affinity between "Eastern" approaches and what they referred to as "post-modern," "post-industrial" approaches to health. This person stated that one of the "valuable things about having a number of Eastern traditions start to infiltrate a more Westernized industrial revolution way of thinking about humans" (I #2, personal communication, April 22,

2015) is that it has provoked a shift away from a "machine like" focus on the relationship between productivity and health. Health used to be understood as "Can you do what you need to do? Are you a part of the functioning capitalist machine? Then you are healthy"(I #2, personal communication, April 22, 2015). But now, with the influence of "Eastern" approaches, people are increasingly realizing that "health is different":

> Health is whether you can bear weight without collapsing, whether there's a general sense of resiliency. It is deeper than thinking about it in terms of what you can and cannot do. Rather, we should ask, "How do you experience what you do? What is your connection to all of the other things that are around you? What are the other ways in which your life is being pushed and pulled?" So I think of health as web-like. Health is not just about some individual automaton. It's about an actual functioning ecosystem. (I #2, personal communication, April 22, 2015)

For this informant, the East is implicitly Other not only to the West bust also to capitalism and industrialism, suggesting a kind of nostalgia for a time-space external to or outside of capitalist modernity.

This informant very deftly captured the 1960s "human capital" logic of health as an economic input and a resource like any other, as articulated by the Hall Commission. For Hall (1964), the investment in a national system of health insurance was a sound, nation-building economic decision, just as the investment in national rail infrastructure was in the 19th century, because health care was an investment in the future strength and productivity of the workforce and therefore crucial to the production of surplus. The informant quoted above not only captured this logic but also suggested that we have moved beyond it, to a more human, less atomized and less instrumental conception of health. Health no longer depends on the presumption of individuals as "automatons," but encapsulates an understanding of connection, "an actual functioning ecosystem." However, the language used—that is, the language of resilience—and the multifaceted and interconnected nature of health suggested by terms like "web," still strongly echoes the health-promotion logic. This logic, arguably, reflects the unique

economic and human capital logic of health in our own era: health as a *personal* and *moral* investment to be pursued precisely because resilience is a precondition of the imperative to optimize one's life energies in the service of the reproduction of post-industrial capitalism. The disappearance and re-purposing of the industrial landscape of Toronto does not mean that the labour, whether paid or unpaid, of reproducing the capitalist social order has disappeared, as this informant appeared to suggest. It simply means that this labour takes new forms and new spaces. This could include, for example the volunteer labour that maintains the clean, green aesthetic of the Roncesvalles BIA, or the labour of "energy exchange" whereby yoga studios offer free classes in exchange for a few hours of cleaning or administrative work. This work helps to keep the yoga studio around as a place where the artists and knowledge workers of the "creative class" can come to take some time out.

Figure 6.5 Yoga for the Masses: Distillery District, June 21, 2013.[16] (Source: Cityscape Holdings, Inc.). Reproduced with permission.

[16] Distillery District, OM TO, Summer Solstice Festival and Colon Cancer Fundraiser. The area is former home to the Gooderham and Worts Distillery, a key 19th century Toronto industry. It was "reborn" in 2001 as "a pedestrians-only village entirely dedicated to arts, culture and entertainment" (http://www.thedistillerydistrict.com/our-story/history-of-the-distillery-district/). The clock, centred in the photograph, would have served to discipline the time of distillery workers. Now, it serves as aesthetico-historic centrepiece for a new form of discipline. http://www.thedistillerydistrict.com/om-t-o-summer-solstice-yoga-in-the-distillery-district/.

The metaphor of connection also depends on an understanding of contemporary health practices in the new wellness industries as less alienated and alienating than biomedicine, and even as holding the key to overcoming alienation. Yet, in contrast to a Marxian understanding of alienation, in which the question of work figures centrally (alienation as the condition of being separated from the conditions and the products of one's own labour), the question of work and its impact on the body is conspicuously absent in most informants' reflections on the subject of health. For example, when asked about ill health and its causes, they frequently invoked notions of balance and being out of balance, as well as "stress," but no one expressly referred to the difficulty of "balancing" the demands of paid and unpaid work, or to specific work-related illnesses. And when work did come up in discussions of health, typically the observation they offered was that health and wellness meant fewer sick days away from work, an optimizing message which resonates with, but also extends, what David Harvey argues is the specifically capitalist definition of health as the ability to work (Harvey, 1998; see also Berlant, 2010).

In this context, a comparison of the relatively disorderly bodies practicing yoga in Figure 6.6 (below) with those highly ordered bodies in Figure 6.5 (above) is telling. In the latter image, the photographer has captured a moment permeated by order and discipline. The clothing and comportment of the women pictured is striking for its uniformity. The picture was taken at a summer solstice festival in the distillery district, where this pagan, pre-modern temporality is celebrated throughout the day with yoga classes. Significantly, the formerly industrial, but now heritage monument, clock stands at centre. In this way the preindustrial, the industrial, and the post-industrial have been collapsed into one another in this orderly assembly of bodies.

In contrast to many of the informants cited above, for one community acupuncturist (I #7), who specifically described the population that they serve as "working class," the themes of "optimization" took a back seat to the pragmatic business of restoring or improving functionality and the ability to cope with life's many demands. Here too, however, the theme of crisis emerged in this person's remarks, which described health as the ability to

> lead your life and function without uncomfortable amounts of pain, distress, worry, anxiety. What my patients tell me, when they're in a course of treatment with acupuncture, is: "I can do these things I couldn't do before." For example, maybe it's a student who's struggling with deadlines and having to hold down a job and turn in papers and so forth. What happens is, people will come in to get their acupuncture and end up realizing that they are completely over capacity. (I #7, personal communication, June 15, 2015)

Here we can see two distinct things happening. First, there is the treatment of specific complaints and the ability to help people "do these things [they] couldn't do before." At the same time, there is a more general therapeutic aspect in creating a space where people can realize or acknowledge that they "are completely over capacity." As this informant further elaborated: "[community] acupuncture is brilliant for this. It can be very non-threatening because people walk in to a room where there are other people who are just basically relaxing" (I #7, personal communication, June 15, 2015). For this respondent, the ability to manage all of life's demands was paramount; the deeper experiential pleasures of health did not come up. For this person, the community acupuncture space gave people a place that could be very relaxing and non-threatening, giving people time and permission to take a break, while also receiving therapeutic benefit for a complaint such as pain, anxiety, and/or digestive issues. But it is also clearly articulated to specific forms of work, such as managing schoolwork and paid employment.

Similarly, one yoga studio owner (I #6) was explicitly critical of the way in which yoga had become deeply enmeshed in the fast, competitive pace of contemporary urban life. As the

informant put it, people "think they're going to a yoga class, but they're just doing more, more, more in the yoga classes. To me that's not yoga, that's just an extension of the crazy pace of life that we're always trying to keep. Yoga should be a place where you can press pause" (I #6, personal communication, 2015). Creating a place to "press pause" on a daily basis was integral to this person's personal practice; and the inability to run an economically viable yoga studio without adding all of the "more, more, more" was identified as a key challenge. Again, similar to the community acupuncturist, who observed that people realize through acupuncture that they are "completely over capacity," the latter informant stated that many people came to yoga "because they are in crisis… physical crisis or mental crisis. For example, they may be they're having anxiety attacks. I've had many people show up at yoga class for different reasons like that" (I #6, personal communication, 2015). Interestingly, this informant stated that the growth of yoga is attributable to the very stressful nature of the "times that we live in." The following passage offers an understanding of the timing of *when* yoga "took off" both across the city and in the Roncesvalles area:

> Yoga culture was spreading before the turn of the millennium, and certainly it was quite strong in the US before then. But it was just after that that yoga took off across the city [i.e. Toronto]. It's because of the times we live in, which are very stressful times. I have a friend who teaches in on the other side of the City. She noticed that after 9/11 her classes got really busy. After 9/11 the bars got really busy and so did the yoga classes. (I #6, personal communication, 2015)

By contrast, the community acupuncturist cited above (I #7) did not see the growth in acupuncture and community acupuncture settings in Toronto as necessarily indicative of any broader social changes per se. That informant stated:

> I think that need has always been there and that the minute you make affordable acupuncture available to people and they know about it, they will come flooding in. That is my understanding of the movement, which is still quite young. And the people who come are not the typical types of patients that I was trained to expect when I was studying acupuncture. Why? Because I was trained to practice based on a 1-1 treatment model. But the people who come to community acupuncture aren't the kind of people who can afford to pay that much for a visit. So I absolutely don't think you can separate

> the growth of community acupuncture from questions of class and economic realities. (I #7, personal communication, June 15, 2015)

Here acupuncture, and community acupuncture in particular, are understood as addressing long-standing needs that many working class people do not have other (or better, or less expensive) ways of addressing. The evidence for this informant was that as soon as you make it available people "come flooding in."

For some informants, both the cause and cure for stress as a form of modern urban suffering had an implicit urban geography. Interestingly, two separate yoga organizations were involved in providing yoga to marginalized and "at risk" communities at no cost with the express aim of bringing yoga to people who would not otherwise have access. While one organization was exclusively devoted to charitable yoga work (I #3), another had a charitable "branch" as part of a broader yoga and holistic health business (I #2). The former organization is a registered charity with a mandate to serve "at risk" youth populations. This work takes them to youth detention centers in southern Ontario to offer special programing for young people in custody, and to Toronto District School Board classrooms in "priority neighbourhoods." The latter yoga organization does not focus exclusively on the charitable provision of yoga classes; rather, it is a commercial holistic health centre with a charitable branch. Thus, the charitable activities of the organization are just one aspect of what the organization does. Both of these informants highlighted the racial and class exclusivity of "mainstream" yoga practice, and both chose to address this problem by developing philanthropic activities. For example, explaining the decision to incorporate an "outreach program" into their business model, one yoga practitioner stated:

> there are a lot of invisible barriers to walking into our studio space. A big one is the location, and there are also identity barriers. A lot of people that practice here look more or less the same, and there's a kind of affluence that is associated with yoga culture right now. And there's definitely race segregation, so I think people feel uncomfortable walking in. (I #2, personal communication, April 22, 2015)

The informant went on to explain how these problems of identity, location, and "race segregation," as well as the problem of limited opportunities for recently trained yoga teachers, were solved by the organization simultaneously:

> Consider, for example, a group of newcomer women in Felmingdon, or Thorncliffe. They have kids, or they have obligations, maybe they don't speak English very well or it would just take them an hour and a half to get here, let alone back, and so they can't come here. Which is why we just started matching people who had the drive, once they finished their teacher training, to go work and give classes in different kind of places, not studios, and there are certainly enough classes to fill. (I #2, personal communication, April 22, 2015)

Flemingdon (Flemingdon Park, neighbourhood #55) and Thorncliffe (Thorncliffe Park, neighbourhood #44) are two of the 31 neighbourhoods designated by the City as neighbourhood improvement areas (NIAs) according to the Strong Neighbourhoods 2020 strategy, and as priority areas since 2005. They are adjacent neighbourhoods, separated by the Don River, in the Don Mills and Eglinton area. In the above quote, women in these neighbourhoods are seen as being unfairly excluded from the benefits of yoga, due to time-based and financial barriers that are linked to their status as recent immigrants. Interestingly, when I asked the informant whether there were any yoga studios in the areas concerned, the person said that they believed that there were. The organization represented by that informant began offering free classes at community services centres in the Flemingdon and Thorncliffe areas (among others) as a way to address this the "race segregation" that the informant observed as part of contemporary yoga culture. The picture painted above has an implicit geography wherein the racially "segregated" belong to specific neighbourhoods, at some distance from the informants' own neighbourhoods. This is notable given the proximity of Parkdale's own racialized poverty. Furthermore, it suggests a shift away from the perception of Parkdale as a "social services ghetto," and towards a space that is rich in privately provisioned services, and positioned to "export" such services to other areas of the city. Ironically, the

informant also discussed how it was becoming difficult to find yoga instructors who could teach in Flemingdon and Thorncliffe, due to the lengthy commute it entailed.

Importantly, for the informant discussed in the paragraph above, the value of yoga to newcomer women was self-evident. The main problem to be solved was a perceived lack of access (I #2, personal communication, April 22, 2015). The speaker below (1 #3), the founder of a Parkdale-based yoga philanthropy which provides yoga classes to "at risk" youth (I #3, personal communication, April 27, 2015) in institutional settings in Toronto and southern Ontario, explained the decision to become involved in yoga "outreach" work in terms that were both similar and different. On the one hand, the latter informant made similar observations about who was not participating in yoga. On the other, the reasons for *why* yoga ought to be made available to a particular demographic were much more clearly formulated, and, importantly, backed up with reference to scientific and neurological research.

The informant (I #3) explained to me that as an adult who had experienced trauma as a youth, "yoga, mindfulness, meditation, were a big part of healing for me" (I #3, personal communication, April 27, 2015). In a set of observations about who does and does not attend yoga classed, this informant further explained:

> when I started working in a mainstream yoga studio business I felt really aware of who wasn't coming through the door at the studio, and in general that was just young people. Young people were not really doing yoga at the studio I worked at or at other yoga studios I had seen. Also, more specifically, I was very aware of the demographic of people that were accessing yoga studios, both where I worked and at other studios where I practiced. (I #3, personal communication, April 27, 2015)

For this informant, the exclusion of young people from yoga was problematic. Motivated by the informant's own experiences of psychological healing through yoga, that person therefore endeavoured to find a way to

> introduce these practices to other young people that might be facing something similar to what I was facing when I was young. So we asked ourselves: where are these practices the least available to young people? Where would they have the *least* chance of

> encountering something like this? So we decided to go to those places where, if not for us, young people probably wouldn't have the chance to be introduced to these practices. And for us that meant going to the most marginalized communities: jail facilities, low-income communities, and so forth. (I #3, personal communication, April 27, 2015, emphasis in original)

In this way, the founding goal of the organization is to bring "at risk" youth in marginalized communities in contact with the practice of yoga. Here, we see yoga as a site of race and class privilege, and simultaneously imagined as a potential solution to some of the effects of marginalization, conceptualized first and foremost, as "trauma."

In further explaining what yoga could do for marginalized youth, this informant drew heavily on neuro-scientific research and ideas about neuroplasticity. In doing so, the informant explained how yoga can be a practical tool for helping marginalized and racialized youth alter their emotional and embodied responses to "triggers," "stressors," and "trauma," which this informant associated with the forms of marginalization experienced by their client base.

> for the most part we work with youth in higher risk environments. What that means is that many of people we are working with have what you could call trauma, or adverse child experiences, things that have affected their nervous systems. And these kinds of experiences cause them to be more hyper vigilant, on guard, reactive. Or, at the other end of the spectrum, it may cause them to become lethargic, under-reactive, and under engaged. All of these behaviours have to do with the nervous system, and with fight-and-flight-type reactions. Yoga-based practices are well suited for this, because they deal with the nervous system. We're at a really important time right now where there's actually research to back this up. (I #3, personal communication, April 27, 2015)

Here embodied experience and behaviours such as "hyper-vigilance" and "lethargy" are understood as the embodied responses to racialized marginalization. They are configured as self-evidently sub-optimal, abnormal, and crying out for correction. At the same time, the working assumption that authorizes the charitable provision of yoga in these spaces is that these experiences and behaviours are characteristic of some communities and not others. And, importantly, it is these behaviours—not poverty, say, or the criminalization of blackness (Cole, 2015)—that is the problem to be solved.

In various ways we can understand CAMs as providing solutions and also *places* for the resolution of crisis. Practitioners actively cultivate the creations of places and times where, for people in crisis, there is a geography of crisis and its resolution at work. —The crisis could be understood as the stress associated with being a working adult in a competitive capitalist economy, or a young person who has strayed from the path of "optimal [brain] development, and therefore, from the potential to be a productive adult worker. These places are heterotopias of crisis and normalization. They function as physically Other places, whether as yoga studios or detention centres, where those who understand themselves or are understood by others to be in crisis can go or be sent. But they are also Other in terms of their experiential qualities: the experience of time and space is qualitatively different from the ordinary or normalized time of capitalist urbanism.

4. The Problem of Luxury

In this section, I discuss gentrification through the lens of the "problem of luxury" as CAM providers in the area articulated it in various ways. The problem of luxury figured prominently in discussions with the informants interviewed for this research. For some the cultivation of a luxury experience, one that represents a break from the spatiality and temporality of capitalist everyday life, was a key element of the therapeutic offering. However, "luxury," or the appearance of being "too luxurious," also posed problems for some health and wellness entrepreneurs, either because the increased cost of providing a luxury experience excluded some patients, or because the perception that "this is not for me" might cause people to opt out of services for reasons that are not purely financial. In the latter case, providers negotiated the problem of luxury by positioning their services not as a form of escape from capitalist urban life (who has the time?), but as something that can be integrated into the busy pace of

modern urban life. In other words, their services were positioned as a form of consumption that does not require the consumer to take (too much) time out. Thus, paradoxically the normalization of luxury consumption as "ordinary" and "everyday" cultivates an aesthetic of equality even in the midst of growing inequalities. As the following passage about the owners of Body Blitz, a Toronto-based, women-only spa chain that recently opened a store on Roncesvalles Avenue as part of an expansion of operations into the provision of "express" facials for "both genders," explains:

> After spending 10 years offering therapeutic and communal waters to women with Body Blitz Spa and opening a second location on King East, Polley says it felt like a natural progression to go from looking after the body to looking after the face. 'Women and men often think of facials as a treat or indulgence, and like body blitz, we wanted to make it quick and easy and encourage them to incorporate it into their healthy lifestyle,' says Polley. And while the blitz waters are exclusive to women, the blitz facials are not. 'I think men are beginning to realize how important it is to look after themselves and to be proactive in maintaining healthy skin.' (Harito, 2015, citing Laura Polley, CEO and co-owner of Body Blitz)[17]

Here the perception of facials as an "indulgence" as well as something that is only for women, are barriers to franchise expansion that need to be overcome. Thus, the spa-entrepreneur actively seeks to redefine the act of receiving a facial, from a privilege reserved for "ladies who lunch" (Harito, 2015), to an integral part of the health and wellness regime of "ordinary" women and men with busy lives. Luxury in health and health-related services thus stands as a problem to be solved, especially for those catering to the class privileged, but not necessarily to the super rich. In this case, luxury needs to be positioned as both "affordable" and "everyday."

A third stance on the question of luxury came in the form of explicit critique. For example, one acupuncturist with whom I spoke was explicitly critical of spa-like organizations, seeing this as a barrier to access, and therefore to diversity. A desire to reject the class bias inherent in expensive one-to-one acupuncture treatments led this person to reinvent their own

[17] Access to the "communal waters" is $60.00 for 2.5 hours, maximum (https://bodyblitzspa.com/index.php/about-the-waters).

practice along the lines of the community acupuncture movement originating out of Portland, Oregon in the early 2000s. In reference to the organization of their current practice, this informant stated:

> The mission of the organization is to make acupuncture accessible to as many people as possible, and to be inclusive to types of people that we feel probably don't feel very welcome by a more traditional holistic health set up where you have this luxury element. In some places it might even feel a little bit like a spa treatment. Our setup is very different from that. (I #7, personal communication, June 15, 2015)

This latter informant is carving out a different discourse than that which is dominant and expressed by the majority of practitioners I interviewed. The informant (I #7) articulates the spa experience not as an antidote to the stresses and strains of capitalist urbanism, but rather as a barrier to access for people in pain and distress.

4.1 The Rent Gap

These variable orientations towards luxury can be understood in terms of the dynamics of capitalist urbanism and the ways in which different types of practitioners and entrepreneurs navigate the imperatives to pay rent and to generate income and profits. Indeed, high and rising rents were a concern for a number of practitioners, and all the informants at some point mentioned the need to "pay one's rent." Interestingly, three of the 11 people interviewed used the term "gentrification" to identify the changes they witnessed around them. While noting that gentrification was already underway before the construction project discussed above, two practitioners who were located on Roncesvalles Avenue specifically connected the "rejuvenation" of the street with an escalation in gentrification, which they understood in terms of rising rents, a changing commercial landscape, and changing demographics.

One informant, who was concerned about the effects of rising rents for the viability of small businesses in the area, noted that the Roncesvalles area had been undergoing

gentrification for some time—in their estimation, 10-15 years.[18] However that person flagged the construction project as a significant moment of intensification, stating

> it used to be that on Sunday the streets would be empty on Roncesvalles Avenue. That's how quiet it was. There would be maybe two stores open. It was a really quiet neighbourhood and people thought of it like it was the suburbs, very different from living downtown. But now it's really gentrified especially since construction on the roads on Roncesvalles Avenue which took three years almost. A lot of places closed during that time and when they reopened, they were different and they catered to a different clientele. That's when things started changing a lot on the street. (I #6, personal communication, 2015)[19]

In this narrative, the informant evokes a time prior to changes in the Sunday shopping laws, when shopping was not yet "normal" on the streets of Toronto. At that time, the many churches in the area functioned as Christian sanctuaries from urban capitalism. Now, capital flows "24-7" and yoga has become a form of secular escape for urban dwellers, as well as, at times, a new revenue stream for churches that rent out their space in the face of shrinking congregations. (Klassen, 2012; I #10, personal communication, July 24, 2015)

A naturopath and owner of wholesale herbal medicine business on Roncesvalles similarly explained:

> It's as easy as saying pre- and post-construction. Because for almost two years [2009-2011] they tore the whole street up and it was incredibly unpleasant. Roncesvalles–the whole neighborhood–it changed. So that is a very clearly marked example. Before that, it was less gentrified and post-construction it's increasingly gentrified. (I #1, personal communication, March 28, 2015)

This informant noted that rents went up along the street, in some cases doubling. This had the effect of pushing some of the "older" shops out, including the previous proprietor of a similar business in the space that this informant now occupies. Offering a textbook example of the rent gap dynamic, the person further elaborated:

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[18] Fifteen years would place the perception of changes at around the turn of the millennium, the same time when the commercial landscape begins to have a growing number of the new wellness industries.

[19] Barque (a play on "bar" and "barbeque") is a trendy restaurant, the first of several to open its doors after the construction was completed.

> A big part of the reason the old owner isn't here anymore is the rent. When the rent went up the margin of profit basically disappeared and it simply wasn't a sustainable business anymore. The only reason my business survived is because I already had another business in addition to my practice. I had an entire wholesale herb business that I moved in here along with my ND practice. That wasn't being done before, and that allows us to remain as a viable business. (I #1, personal communication, March 28, 2015)

Additionally, the informant indicated that part of why the new business will be viable in that location is that it has multiple offerings and multiple uses for the space: a clinical practice, a community acupuncture practice, and a commercial and a wholesale herb business. Combined, these uses of the space render it a viable "for-profit business" (I #1, personal communication, March 28, 2015). To the extent that this dynamic also draws service providers who wish to embody the neighbourhood ideal as a place to "live, work, and play" by working close to where they live, it also contributes to the residential gentrification dynamic.

These quotes also suggest that people are quite aware of the ways in which the rent gap shapes the character of the street. The successful businesses are those that can adapt to the changing exigencies of the "class remake." Others will be left behind and forced out. As larger chains move in, this dynamic could be repeated with today's "winners" becoming tomorrows "losers." And indeed, the two most recent health and wellness enterprises to open doors on Roncesvalles Avenue are Toronto-based chains. In June 2016, the Blitz Facial Bar, discussed above, opened a store there. Similarly, in 2015 the Village Juicery, also mentioned above, opened a location on Roncesvalles Avenue as well.

However, different informants understood the relationship between their business and the broader neighbourhood in which they are located in different ways. For example, one yoga instructor suggested that the presence of their organization on College Street might be a catalyst for broader changes:

> I don't know if gentrification is the right word, but it feels like that a bit. One thing I do notice—which is probably because of us, and also the gym down the street—there's a

> whole bunch of juice stores. So there's a lot more people in the neighbourhood who are looking for healthier food, which is kind of cool. (I #2, personal communication, April 22, 2015)

Here the informant suggests that their organization may be an agent in gentrification, along with other types of businesses such as juice bars. However, this is taken as a positive development—"kind of cool"—since the combined aspect of people doing more yoga and drinking more juice is taken as indicative, first and foremost for the informant, that "people" are looking to be healthier. What is not asked or considered is who can participate in this newer and better lifestyle. This is especially significant in the context of stated desires for diversity and accessibility, as will be discussed below.

4.2 Of Spas and Boutiques: Producing the Therapeutic Experience

Several informants flagged the importance of "boutique" or "spa-like" qualities in determining the kinds of establishments that would be successful and able to attract clientele. This conforms to Mazer and Rankin's finding that "residents of single family homes indicated their preference for shopping outside their non-gentrified neighbourhoods, and proprietors of trendy boutiques on gentrifying strips derided '"older stores' for their cluttered, unattractive appearance" (2011, p. 829). As one practitioner on Roncesvalles explained:

> As the neighborhood got fancier, we had to—and I also kind of wanted to—have an increasingly nice space. The old junky, junk shop look just doesn't work in this neighborhood anymore. We prefer to think of ourselves as an herbal boutique rather than an apothecary. (I #1, personal communication, March 28, 2015)

For another respondent the possibility of further transformations along the lines of environmental gentrification was unequivocally something to look forward to, because it would make the area more of a destination or a "hub" for certain kinds of health and lifestyles, understood as "natural":

> If more of these kinds of spaces open up then it would become a more desirable place for people to come and work. It might get known as a kind of natural hub. It's changed a lot since the water main construction. And there are yoga studios opening and there's

> a couple of condos coming that are LEED [Leadership in Energy and Environmental Design] built, so I think that whole environmental consciousness is coming up everywhere in different neighbourhoods. And I think this neighbourhood is certainly going to—if it hasn't already—I think it's definitely going to jump on that bandwagon. (I #8, personal communication, July 15, 2015)

This desire for a spa-like character and/or a more natural environment was also articulated as a strategy of distinction, a way to set themselves apart from other kinds of spaces and practices. For example, the owner of a multidisciplinary clinic in Liberty Village stated:

> I wanted to create a space that looked like a spa, but wasn't a spa. What I mean is that you wouldn't necessarily see people walking around in bathrobes, chilling and relaxing. However, I also didn't want it to have a clinical feel, like you were walking into a doctor's office. So that's the difference. (I #9, personal communication, July 22, 2015)

In reference to the challenges of working out of a conventional medical arts building, rather than a storefront or stand-alone space, two informants explained:

> The word is getting out that we're here and we have a fancy sign outside with a different kind of aesthetic, more natural than what you'd expect a conventional medical setting. Our space just *looks* different so that catches people's attention. (I #8, personal communication, July 15, 2015, emphasis in original)

> It's common for people to express surprise when they come in because on the outside it's an ugly, conventional building. But inside we have hardwood floors, gorgeous shelves made of wood, of trees, and it's really nice. (I #11, personal communication, July 15, 2015)

These informants articulate a desire for a distinction of the character of their workplaces, which is comprised of a connection to nature, a "break" from the time-space of capitalist urbanism, and a nominally "decommodified" aesthetic experience. Hence, the importance of having a certain kind of aesthetic to attract customers, and to "fit" with the neighborhood. At the same time, however, they describe processes of change in which they too are inexorably caught up, and which, whether intentionally or not, are slowly redefining the character of the neighbourhood and the bodies and lives that may belong to it. Mazer and Rankin capture a somewhat different perspective on these processes. The authors quote a rooming house tenant in Parkdale as follows: "There used to be a lot of places you could go and pick things up

reasonably cheap. But…the stores are 'elite-ing' themselves…. You can't afford them. And a lot of them are places that I'm not interested in, because they're just things I don't do" (anonymous interviewee, cited in Mazer and Rankin, 2011, p. 829). In this way, we can see that the desire for a "natural hub" which will draw more people to the area is also a process whereby others are displaced, marginalized, and excluded, not only from place but from the remaking of "health" with which it is bound up.

The references to wood and trees in the above quotes from practitioners on Roncesvalles Avenue are especially significant in light of the foregoing discussion in Chapter 5. The politicized nature of trees as markers of life and vitality, as well as the authenticity of a certain kind of professional expertise, is apparent in these statements. Particularly significant is the fact that the third informant, in contrasting the "nice" (tree-full) interior with the ugly (bricks and concrete) exterior of the building, self-corrects when renaming the material that the shelves are made from ("trees" not "wood"). On the one hand, this can be read as expressing a desire for an "authentic" decommodified substance: wood being less "natural" than trees, uncontaminated by processing and by human labour. On the other hand, it also has the effect of bringing the political, commodified, and property status of trees into the frame (Braverman, 2008). Whatever their health or therapeutic benefits, trees here are also positioned as commodities and as integral parts of the branding and marketing strategies used to produce distinction, both by the Roncesvalles Business Improvement Area, and by these health and wellness practitioners. For these practitioners the distinction to emphasize is that between their own practice and those "more clinical" (i.e. publically insured?) services for which people may not need to pay out of pocket. Nature thus becomes part and parcel of the value added, the thing to be paid for over and above tax-financed health services. Thus, we see the use of

natural, floral and tree-full sensibilities being mobilized to produce a seamless line from nature to the body through commerce.

The "spa-like" aesthetic sought by some practitioners was explicitly rejected by some others who connected it to gentrification and to other forms of exclusion, as did the community acupuncturist mentioned above. Another respondent, a long-time resident of the area who has been practicing yoga for three decades, was in the midst of trying to understand why their yoga business was less economically successful than some others in the area. This informant noted the way in which both the Roncesvalles neighbourhood as well as the practice of yoga itself had changed:

> When I first started doing yoga a lot of classes were in churches, or in schools, and we'd practice on the wrestling mats. It didn't really matter much what the place was like. What mattered was what we were doing in the class and the surroundings were fairly basic. But now people are putting so much money into building yoga studios and they are creating an atmosphere that's more like a *spa*. They're adding saunas and change rooms and lockers, and the result is that these days, going to a yoga studio is like going to a high end, boutique gym. (I #6, personal communication, 2015 emphasis in original)

Importantly, this informant associates "spa-likeness" not only with an aesthetic, but also with the scale and variety of health and wellness services and options. They also associate the ability to attract a certain socioeconomic demographic with that demograhic's ability to "pay a bit more," "have a membership," "drive [to the location] and pay for parking," and enjoy "all the other add-ons that go with it" (I #6, personal communication, 2015).

These comments highlight the importance of the organization of services, whereby multiple types of products and services are offered in the same space (see Table 6.3, above). One yoga practitioner explained the decision to have multiple offerings out of one studio space in the following way:

> We wanted to create more than just a yoga studio, so instead we made a place that was focused on holistic health, with yoga as a touchstone. We have many, many therapists who work in our clinic, practicing nutrition, psychotherapy, naturopathy, Registered

> Massage Therapy, and we even have a salad and juice bar on site. The reason we have all of these different things is because we think that it all works together, that all of the threads tug the web. So what that means is that we are bringing people into a yoga class that is also inspired and pushed and pulled by all of these other things around us that are also sources of healing. (I #2, personal communication, April 22, 2015)

In this narrative, the informant explains the expansion of services as a logical outgrowth of a commitment to a particular kind of understanding of health: holistic, healthist, and connected to all aspects of living and being, as in a web. However, for many, the economic rationality of this form of organization was key. A Registered Massage Therapist (RMT) and Traditional Chinese Medicine practitioner who owned and operated one large space in Liberty Village and another in the University and College area, explained that they wanted to

> create a space where different practitioners work out of and create their own business. I wanted to create a space that would be able to pay for its basic expenses without the person who is signing the checks having to put a lot of money into it, since that person is the one who created the space in the first place. So that was the goal, and it still is the goal still at this point. The space has recognition, because of its brand name, and people come to it for that reason. (I #9, personal communication, July 22, 2015)

Here the multidisciplinary clinic is an economic and rent-extracting strategy on the part of the clinic's founder. In creating a space with name recognition in order to draw clients in the door, the informant could exchange the obligation to pay rent for other kinds of obligations associated with the production of a valuable brand.

It is important to flag that the perception of "spa-likeness" is subjective and variable. This is highlighted in the contrast between comments made by two different informants in reference to the exact same yoga studio. I asked one to give an example of a "spa-like" yoga studio after this person stated: "My studio is a small, modest studio. It doesn't have that spa-like atmosphere that a lot of studios have these days" (I #6, personal communication, 2015).

Figure 6.6 Yoga for the Masses: City of Toronto Community Center, February 27th 1975. City of Toronto Archives. Fonds 218, Series 1762, File 868. Reproduced with permission.

As it happened I had already interviewed someone from one of the studios that this informant named as being "spa-like" and "boutique." Here is what this person had to say about their own studio:

> We have a pretty different atmosphere than some of the yoga studios in town…. We're not very fancy, we're pretty casual and we're about connection. And that seems to really resonate with people in this area. (I #2, personal communication, April 22, 2015)

I asked for an example of a "fancy" studio to get a clearer idea of what this informant had in mind.

> JP: So what would you say is an example of a 'fancy' place?
> I #2: That's a really good question. I'm thinking of a studio in Rosedale that is a very refined yoga studio. I think that they have a very different clientele there, and they're extremely professional and put together in a way that serves that community very well. But this is a different kind of community and we suit it well. (personal communication, April 22, 2015)

Clearly, then, there is a continuum of spa-like quality and experience, and it is important to get the right "fit" between the aesthetic experience of the interior space, the neighbourhood in which it is located, and "community" it strives to serve. While made in reference to the same

space, the criteria for being characterized as "spa-like" were somewhat different. The latter informant, referring to a studio with which they are affiliated, seems to associate the adjectives "spa" and "fancy" with an attitude and disposition: one of "polish" and "refinement." Thus, we see here that luxury is a problem to be solved: how to offer a service that requires a certain level of financial and temporal "investment" without being perceived as too elite or too exclusive for the neighbourhood where one is located. For as much as Roncesvalles may wish to be "not Parkdale," it is also not Rosedale.

4.3 Diversity, Access, and Inclusion

The discussion in the previous section foregrounds the significance of the interrelated issues of access, inclusion, and diversity for many of the informants who participated in this study. Paradoxically, the informant who represented the holistic health centre and who explained that "race segregation" was a key reason for establishing the charitable branch of their organization, also explained the success of the commercial enterprise in the following terms:

> Our community is very diverse. The people who come here are artists and waiters and waitresses and people who have daytime hours free, so our daytime classes are quite busy compared to other spaces. But we also have a lot of professionals and parents who take classes in the evenings or in weekends, so those classes are always really busy as well (I #2, personal communication, April 22, 2015)

This set of observations, which takes up themes of gentrification and city-scale dimensions of socio-economic inequality and their relationship to questions of access and diversity in relation to forms of health and wellness, points to an important tension. Even the most well intentioned efforts may end up naturalizing the geography of the socio-economic and racialized inequality that is well-documented in Toronto. The naturalization of this geography happens when some neighbourhoods are understood to be "diverse" in terms of people's work schedules or their ability to walk, bike, or drive to yoga, whereas others are "diverse" in the sense of being recent immigrants, people of colour, or low-income people. Yet,

even as individual practitioners and businesses may be caught up in the pressure to match "neighbourhood improvement" with "improvements" to their own businesses, thereby contributing to the extent to which rent and affordability shape the future and character of the street, it is not clear that displacement will not someday affect them too. This points to a real challenge in the use and widespread dispersal of rankings that draw on "health" and "wellbeing," among other things, in the effort to quantify neighbourhoods, at times reducing them to a single number. Health is not simply a social fact waiting to be discovered in this or that place or body; it is also produced through these strategies of governance with paradoxical effects for those who have an interest in questions of diversity and economic accessibility.

Many practitioners, both those who understood themselves or were understood by others as being "fancy" or "spa-like," expressed a desire to be economically accessible, both as an economic strategy and as an ethical commitment. Additionally, in a couple of instances practitioners expressed a desire to be accessible and diverse in terms of race, gender, and sexuality (I #2; I #3; I #5; I #7). Interestingly, some insisted that the most effective way to meet these challenges was to find ways to offer services at a lower cost in the neighbourhoods where they were located, or, in a limited number of cases, at no cost in other neighbourhoods across the city that were perceived as having inequitable access and therefore a need for such services. Thus while the question of access was primarily articulated in terms of economic tensions between the practitioner's need to pay rent for space and the relatively high cost and low level of insurance for services, other barriers to access, such as race, gender, and geography, were flagged by some informants.

Efforts to achieve diversity and accessibility were enacted through two main strategies, namely, forms of price discrimination, and to a lesser degree, philanthropy. Price discrimination is the practice of charging people what they can afford to pay for services. This way, one can

optimize business by attracting both lower and higher income clients. The practice was, according to medical historian Malcolm Naylor (1986), common among Canadian physicians prior to Medicare. The phenomena of "pay what you can/choose" yoga classes, as well as sliding-scale community acupuncture, both operate on a similar principle, though with a difference, since in these instances, multiple people are served at the same time, in the same space, and usually by the same practitioner or a small number of practitioners.

Unsurprisingly, the informants linked the question of who does and does not "come in the door" to rent. On the one hand, practitioners expressed that they could not pass any more of their costs on to clients in order to meet the demands of rising rents, since fees for services that are either uninsured, or only insured for relatively small numbers of the population, were already high. On the other hand, the need to earn a living demanded that practitioners develop a busy practice for themselves. More surprising was the fact that two informants, both yoga practitioners, implicitly acknowledged the ways in which the rent gap and its racialized character in Toronto shaped the demographics of their client base. These informants noted that lower income and racialized people tended to live in different parts of the city from themselves and their yoga organizations. Therefore, in their perception, these people faced both geographic and economic barriers to participating in yoga. Both organizations sought to overcome these barriers by bringing yoga to racialized communities in other parts of the city, who, in their view, could benefit from the practice and may not otherwise have access.

One practitioner, a naturopath on Roncesvalles Avenue who also felt that becoming "more boutique" was an important part of adapting to the changes on Roncesvalles Avenue, stressed how crucial price discrimination was to the production of an economically viable business. This informant stated:

> I'm doing something differently than what most non-OHIP covered practitioners are doing. For that category, that fee for service health provider, it's getting increasingly

> difficult to make it because rents go up, therefore your prices go up, and as your prices go up you exclude an increasing amount of the population. There's only about 15% of people in Toronto that have either the coverage or the disposable income to afford full fee services from ND's, acupuncturists, or even RMTs. So that's why, both from a true desire to share, and a business model perspective, I decided to do things differently. (I #1, personal communication, March 28, 2015)

Here the desire to share and the need to have an economically viable business are wholly commensurate goals. The challenge is not necessarily the lack of equitable coverage across the population, or the commodity status of health care. Rather, the problem is negotiating the terrain of value: how to offer high-quality service at an affordable price. As this informant explains:

> One of the challenges is to offer affordable care across the board to everyone, openly, with no restrictions, and yet to make sure that it is not perceived as a discount service. This is not your next-best alternative if you can't afford the expensive stuff. This is the expensive stuff with the option of saying, "It's for everybody." The model that I am using is intentionally set it up so that it's not a charity and it doesn't rely on anything else. So even if OHIP never changes my model will still operate as an independently sustainable *for profit* business. (I #1, personal communication, March 28, 2015, emphasis in original)

There is an explicit effort to distance what is being offered from charity, with the implication that a charitable service would imply something of inferior quality. From the vantage of private profit, and totally independent from concerns about sharing, it is more desirable to have both the clients who can pay for the expensive stuff, as well as those who need a discount, rather than having only one or the other.

While I did not encounter any other practitioners who had an across-the-board policy like that of the practitioner cited above, others did state that they would, at times, offer discounted services on a case by case basis. A recent graduate from the Canadian College of Naturopathic Medicine (CCNM) expressed uncertainty about whether to adopt a similar policy, in part because of uncertainty around the rules laid out by the fledgling Collage of Naturopaths

of Ontario, but also because of similar concerns around value. This informant feared that people would not value their time or expertise if they were to simply give it out for free:

> I would love to be accessible to everyone. This is one of the biggest challenges for me as an ND, is that I can't treat people that can't afford my services. The only other option is to just give out my time. But I also have to live…. Plus, there is a principle at stake: what do people value when it's free? (I #11, personal communication, July 24, 2015)

Another practitioner, who also owned and managed a large clinic with a number of different practitioners, said that it would be up to individual practitioners how they handled the question of variable fee schedules:

> It would be on a case-by-case basis. We don't have different rates for seniors or children. We keep it consistent. However, in my own practice, if someone couldn't afford it I would charge a different rate, absolutely, and I'd be clear about putting it in their file. But it is on a case-by-case basis for each practitioner to decide for themselves. In the past I've practiced where there was no charge involved, in a situation where there was a client who just didn't have money and needed the care. (I #9, personal communication, July 22, 2015)

Community acupuncture and yoga are both therapeutic modalities that lend themselves to the provision of low-cost services to people in a group setting. Community acupuncture is acupuncture delivered in a group setting to people at reduced rates, often on a pay-what-you-can sliding scale between $15 and $35 or $20 and $40, in Toronto. Compared to the $80 to $100 or more for a one-on-one treatment, this set-up makes treatment more affordable, even for those who are not insured; and it makes multiple treatments, apparently the most effective way to receive acupuncture treatment, within reach for more people. As one practitioner explains:

> Our position in the community acupuncture world is that traditional Chinese medicine got migrated into a luxury type of experience for the patient. That happened because of how acupuncture came to North America in the first place and was perceived as a bit esoteric and exotic. In China it's a very basic and humble thing. I've heard that some Asian people look down on it because it's very folksy medicine. On the other hand, in China they also have big acupuncture hospitals. (I #7, personal communication, June 15, 2015)

Thus, community acupuncture is an attempt to get out of the "luxury" mode of provision and bring acupuncture back down to earth, as a form of practical, humble, folksy medicine. However, $15 is still expensive by some standards. Indeed, one practitioner I interviewed remembers going for $5 student treatments at Queen and Augusta in the late 1990s and early 2000s. The community acupuncture model also helped the practitioner to develop a larger client base and an economically viable practice, since the number of people who could afford to pay $15-40 out of pocket is far greater than those who can pay for private treatments. When treating multiple patients, the lower cost offered to the patient did not necessarily reflect a lower rate of pay for the practitioner. Indeed, it could have had quite the opposite effect. Moreover, for those patients that do have a set dollar amount of coverage, the more inexpensive treatments will mean they can stretch their coverage further.

Similarly, a representative of one yoga studio that was run out of a church entirely on a pay-what-you-can basis explained the business model: "we can offer inexpensive yoga to the community, still pay the yoga studio rent, and the teachers can make lots of money as well. So it's kind of like an 'everybody wins.'" (I #10, personal communication, July 24, 2015) This particular organization was in a somewhat unique situation, however, because the yoga studio and affiliated holistic health centre are run out of a church, they are able to pay lower rents than might otherwise be the case. As the informant explained:

> It's a big church building with a yoga studio and other rooms that the practitioners use to treat their clients. Everybody pays rent to the same person who in turn rents the space out from the church. The same person also coordinates all of the practitioners and manages the yoga studio. Because the church has this extra space they are able to make a little bit of income by renting it out. And it's good for the practitioners too, because to rent a room in Toronto for a massage therapist or an osteopath, the cost is very, very high. But in our set-up the rent is quite an affordable rate. And because the practitioners are able to pay a pretty low rate they're also able to charge the community a little bit less than other places. (I #10, personal communication, July 24. 2015)[20]

[20] Interestingly, while yoga practitioners were keen to note the positive impacts that "Eastern" approaches to health have had in the "West," they were also eager to distance themselves from religious understandings of yoga,

This type of organization—where one person manages and organizes a space through which many different practitioners offer services on a one-on one basis or for groups, such as yoga classes or workshops on topics ranging from cooking to meditation to "natural movement" to essential oils—was extremely prevalent both in my interview-based and web-based research into the new wellness industries in Parkdale. These organizations also frequently include other amenities, such as saunas, showers, the provision of complementary tea and water, and so forth. One respondent explicitly connected the increasing prevalence of this kind of social and spatial organization to the pressures of competition and rent: "they're adding all of this stuff because they have to pay their rent, because the rents are so high, right?" (I #6, personal communication, 2015)

As many informants noted, economics is not the only barrier to people seeking particular forms of treatment. One practitioner who sees patients both at a one-on-one practice in Liberty Village and at a somewhat less expensive rate at a school in the Annex where this person teaches, explained that "once upon a time" acupuncture was not accessible to the general population because of language barriers, since most practitioners were Chinese and did not necessarily practice in English. Now acupuncturists are increasingly "white like me," and consequently, more accessible to English-speaking patients.[21] On the question of affordability, this informant notes that whereas treatments in Chinatown were in the range of $20-50 dollars,

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articulating instead an expressly secular interpretation of "mind-body-spirit." In this way yoga was articulated as secular, but nevertheless a powerful antidote to desacralized "machine" understandings of health and the body. The phenomenon of yoga in churches is not isolated to Roncesvalles, as documented by Klassen (2012), who shows how the needs of yoga practitioners for space form a kind of symbiotic relationship with many Protestant churches in the city that face declining church-going populations and therefore a surplus of space and declining revenues.

[21] It is absolutely crucial to understand here that the ascendency of English as a language of practice is not simply a "natural" consequence of more "white people" taking an interest in practicing acupuncture. It is a political outcome of the process through which Traditional Chinese Medicine and Acupuncture (TCMA) became a regulated health profession in Ontario, which it has been since the TCMA Act was proclaimed in 2013. Under this new regime, licensing examinations can only be written in English or French; they cannot be written in any other language. This has led to a situation where practitioners who work only or predominantly in Chinese or other Asian languages can no longer practice legally.

now in Liberty Village they have to charge $110 for an initial visit and $85 for a one-hour follow-up appointment in order to be able to cover the costs of commercial rent, repayment of student loans, as well as residential rent in Parkdale. Even though some people still have access to cheaper treatments in Chinatown as part of a cultural inheritance, and others may go to community acupuncture clinics, even these options are still out of the realm of possibility for many people.

5. Conclusions

This chapter has argued that the motif of "taking time out" to recuperate or the need to "press pause" are connected to the preferences, on the part of some CAM practitioners, for a naturalist and/or an Eastern, Orientalist aesthetic as strategies for producing heterotopias of crisis and normalization. As CAM practitioners distinguish themselves both from "mainstream" bureaucratic medicine, focused as it is on treating diseases and symptoms and not the treatment of the "whole person" in the name of health optimization, and from the stressful, health-depleting time-space of capitalist urbanism, they drew on Orientalist images, associations, and meanings that are already available (Reddy, 2004). In a Canadian context, and in Toronto in particular, there is another mode of valuing difference which is also readily available: that of diversity. As we have seen, many practitioners interviewed for this project did express a desire to be "diverse" and inclusive. There are many good reasons to celebrate diversity; however, the difference between this celebration and an economic strategy of promoting distinction is not always obvious.

The presentation of these healthy commodities in the urban landscape is one which suggests that the biological limits and possibilities of bodily life can and should be modified by particular kinds of commodified practices pursued in situ. This epistemology of health is part

and parcel of how the commercial landscape in Parkdale/Roncesvalles is changing. These changes to the landscape are therefore of a kind that privileges and valorizes certain modes of health behaviour and consumption, and that align with broader, longstanding governmental interests in particular ways. The expressed desires of some practitioners to be "accessible to everyone" notwithstanding, that fact is that they are not. Not only are these health-promoting and quasi-epigenetic optimizing disciplines not available to everyone, but their proliferation is bound up with larger processes which make urban space itself less available to some than to others.

As techniques of subjectification these branding strategies operate in such a way as to affect a seamless line from nature to the body through commerce. This therefore entails a politics of life itself, not only in the language used to describe space or spatial processes understood as "neighbourhoods," but also the spaces and spatial processes of bodies themselves: drink organic juice and *become* radiant, calm, detoxified, clean, and so forth. However, notwithstanding the desire among many practitioners to be "accessible," these services have gone hand in hand with a "class remake" (Smith, 1996) of the area both in terms of who can afford to live/be there, and in terms of the kinds of bodies and bodily comportment that are valorized. As commodities these products and services contain an invitation to a particular kind of subjecthood, a particular kind of consumer citizenship: one that is clean, green, and calm. But this is an invitation that cannot (and perhaps does not want to) be accepted by all. In this way, then, the health of one is at the expense of the other. The optimal life of one is through the diminishing of the life of the other.

Thus, there is a clear shift in the nature of commodities and services on offer, as well as the price tag that goes along with them. The access of the privileged to higher-cost health commodities is a simultaneous moment of the disappearance of access to lower cost and

subsistence resources that once dotted the streetscape, including the Polish delis and bakeries to which the tourist-oriented, gentrification-celebration literature to which the previous chapter calls attention. These changes are not simply a question of inevitable generational change (i.e. children of Polish immigrants not wishing to take over their parents' businesses), or of who is able to purchase what kinds of commodities, as important as this is. These changes are also about new ways of governing and relating to self and others in relation to health and to space.

These changes align with broader neighbourhood and city-wide dynamics. As the previous chapter demonstrated, health care businesses are not the only ones circulating the imperative of health on Roncesvalles Avenue. Recall from the previous chapter the signage of the BIA, which stakes its claims to space in part by asking users to conform to its understandings of "good" bodily comportment: cleaning and gardening yes, smoking no. Taken together we can see that there is a language of vitality and optimization that now riddles the landscape and enjoins people to practice and to conceive of life and health in particular ways. These exhortations can be read in terms of Foucault's assertion that, under the regime of biopolitics, death becomes a mark of failure, and all premature deaths are, in some sense, "suicides" (Lemke, 2011). Life itself becomes a state of crisis—or more precisely, life is permanently at risk of crisis, understood as the failure to optimize vitality.

These changes challenge us to re-examine what is meant by notions of universality and equality in the context of health care. Inequality is a relational question: it is about the relationship between those who have more and those who have less. In our contemporary moment what it means to "have more" in the realm of health care access is changing in important, though under-examined ways. Whereas once "alternative," "complementary," and "paramedical" health services practitioners where the legal and political "have not's" in comparison to their physician and surgeon colleagues, today these types of practitioners are

experiencing a significant growth of popularity, prestige, and authority among certain segments of the population (Achilles et al., 1999; Bohnen, 1994; Gilmour et al., 2004; O'Reilly, 2000). This change has led to another change, whereby some health care consumers have an unprecedented array of basic and luxury health care options. In addition, these consumers have more options for payment, including public insurance; employer-sponsored private insurance; individually procured private insurance; and disposable income payments, either on a fee-for-service basis, or through annual membership to health and wellness service provider organizations. Moreover, these developments are not confined to what are typically categorized as CAMs; private biomedical clinics offering a mix of basic and luxury services and experiences are on the rise in Toronto and in other cities across the country as well (Pailey, Pomey, & Adams, 2012; Shimo, 2006; *Toronto Life*, 2014). These dynamics raise new questions and challenges in the context of discussions around equality and universality in health care.

Rather, the emphasis on youth, life, and re-birth, as well as the moralizing association of these constructs with cleanliness, nature, and "green" consumption, are also enacted through specific forms and sites of health consumption. The floral, tree-full, natural aesthetic so valued by groups engaged in the planning of the redevelopment of the street is also embodied and reproduced through the sensibilities of the increasingly prevalent health and wellness enterprises dotting its landscape. Moreover, the cultivation of a "boutique" aesthetic and experience of natural and alternative health care was sometimes explained by the practitioners who were interviewed for this project as a very self-conscious effort, both to project a particular kind of image of what health is, and to "fit" with the changing needs, tastes, and desires of residents of the neighbourhood as it further gentrifies in the post-construction period. In these ways CAM practitioners are both responding and contributing to gentrification pressures.

Conclusions
Vital Politics: Justice, and Indemnity in the City

or

Who Can be Against Yoga?

This dissertation has documented and theorized a profound shift in Parkdale's political and material landscape. This shift has been shaped by changing health rationalities and their relationship to new urban forms, as they are expressed both in "official" discourse and in everyday consumption practices of the "new middle class." Characteristically, these shifts entail first, the redefinition of health as something holistic, which shapes and is shaped by all facets of living; and second by an emphasis on neighbourhoods and local spaces as the preeminent scale for knowing, managing and assessing the possibilities for life.

Health is not an ordinary commodity. Yet, through this transformation we can see how it is nevertheless a field of commodification. "Universal" public health insurance, or Medicare, was the institutional expression of a broad post-War consensus that recognized this fact and strove, however imperfectly, to make a certain basic level of health available to all* classes and regions. Importantly, it did so not only in the name of better health, but also of regional and class based economic redistribution. At the dawn of the 21st century, we are witnessing a realignment of this social vision, as new forms of health and wellness consumption oriented towards the new political rationality of "life optimization" come to populate the landscape. The effect is such that, in a neighbourhood like Parkdale, people who are unable to access essential goods such as housing and sufficient, nutritious food live "cheek by jowl" alongside those for whom $24/liter juices designed by professional nutritionists and a memberships at boutique yoga studios have become normalized elements of urban life. These changes are not simply the product of individual "choices" and

"preferences" for certain lifestyles. As the research presented here has documented, they align in particular ways with broader governmental shifts in understandings about what health is, how it is obtained and who is responsible for it. Thus, they are emblematic of a rationality that has become normalized to a degree that it is almost beyond question.

Furthermore, these shifts are not only about urban space. They are also about wider conditions of late capitalist relations of ruling and attendant shifts in social reproduction. These health commodities are presented as ordinary and essential aspects of the reproduction of oneself and one's communities as "utopian" subjects and spaces, capable of nurturing successful and productive life, in and for late capitalist society. And, as this dissertation has shown, the craze for costly and exclusive health optimization has replaced street level programs, services and spaces which once served lower income demographic, which still exists. Thus it is not simply the fact that luxury consumption is by definition exclusive. In the field of health the process of luxurification is bound up with broader processes that shape access to the city and to democratic citizenship. And, insofar as these shifts have implications for how people eek out a substantive existence, as well as what ways of existing are deemed valuable and legitimate, they have implications for membership and belonging in "humanity" itself.

This urban politics of vitality is not only a product of the changing landscape of consumption and service provision. It is also a process which is bound up with shifts in how the space of the city itself is known and represented, which in turn shapes knowledge pertaining to the modes of identifying and addressing the salient problems for urban governance to address itself to, today and into the future. In particular, the localization of "success" and "health" in specific "great" neighbourhoods is also part of a process whereby "risk", too, is localized as belonging only to certain spaces, demographics and communities.

This implied binary – which is glossed over by the presumed universality of ranking and benchmarking – indicates the extent to which the space of the social as a space of sharing and collectivizing risks is becoming more invisible. The discourse of the (social) determinants of health has become intimately tied to the process of ranking people and places, for varying purposes. The political economy literature strives to distance itself from an understanding of social determinants that does not take into consideration questions of class, arguing that such understandings constitute "a mere ranking of people". I have sought to show how this "mere ranking" has become normalized as a means for producing a particular vision of equity and justice in the city. Local, place-based, and social determinants of health-informed rankings are offered in the name of mitigating risks to, and optimizing the possibilities for health and for life itself. As such, these risks are not strictly individualized. They are localized on particular geographies and collectivities that are construed not simply as threats or dangers to their own success, but to that of the global city as a whole. It is through the techniques of wellness ranking that the global city can be read as indemnifying itself, not only against the uncertain futures of late capitalism, but against other visions of justice as well. But, of course, there are forms of collective action, resistance, and contestations of these processes that this dissertation has not discussed or documented, and where social space continues to be created.

Taken together, these shifts suggest that we are witnessing a distinct urban politics of vitality. This politics of vitality is evident in the processes through which the value of urban space, as well as the bodies and lives of urban residents, come to be assessed along the lines of an imperative to optimize health, and can be observed along three mutually dependent axes: first, a vital politics of urban governance, as public health has moved, at the local level in Toronto, from a distinct government agency/bureaucracy to a central component of how

the physical, social and financial infrastructure of the city's governance are conceptualized and evaluated. Second, a vital politics of space: the ways in which money, labour, and emotional resources are directed towards the modification of space along lines which are presumed to be connected to the enhancement and promotion of health and/or the deflection of disease susceptibility. Third, a vital politics of citizenship: health promotion redefined the relationship between health and citizenship in ways which de-emphasized public responsibility and re-emphasized private responsibility for health. However this mode of responsibilization *called out* or *created a need for* ways to enact and perform these new citizenship duties. The new wellness industries have emerged in ways that effectively function to fill that need. But, as more numerous health commodities appear and proliferate in the urban landscape, only some urban residents can participate in the forms of bodily modification and optimization that these products and services promise, while others whose bodies are deemed sub-optimal are written out of the story of the successful city and even portrayed as a threat to it. Who can be against yoga when what it promises is something like a path to a more fully human experience? Yet, the flip side of this is that in the late capitalist, healthified city, some people – disproportionately poor and racialized – are not only expelled from space, but also from what is seen as being fully human.

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Appendix A: Interview Process & Method

In the spring and summer of 2015 I conducted 11 open-ended interviews with key-informants in the complimentary and alternative health and wellness industries, in the Parkdale area. I identified 33 core organizations by visiting the neighbourhoods and by performing Internet searches. I visited the neighbourhood to make a list of all the CAM health organizations visible from the street and to record their names and addresses. I also used Internet key word searches to identify any organizations that I may have missed, or that were not visible from the street. I then visited the websites of these organizations to learn about the services offered and to identify potential interviewees. I contacted at least one person, preferably in a leadership position in each of the thirty-three identified organizations in Ward 14. The majority of these organizations had addresses on Queen Street West and Roncesvalles Avenue. I attempted to speak to people who were well positioned to speak to their respective health discipline(s) as well as the history and nature of their organizations. Five of the eleven people with whom I spoke were in leadership positions as founder/director of the organization, and one was the founder and director of a particular branch of programming within their organization. Eight respondents were affiliated with organizations with address on or directly adjacent to Roncesvalles Avenue. Two key informants were from organizations with addresses in the Liberty Village BIA part of Parkdale (South West of King and Dufferin), and one in Little Portugal/Brockton (College Street West). Unfortunately, none of the organizations located on Queen Street West in the "heart" Parkdale responded to my request for an interview. The fact that the majority of respondents were from a Roncesvalles address is partly explained by the relative abundance of health and wellness organizations on or directly adjacent to Roncesvalles Avenue (see Table 6.1, chapter 6 above).

Interviews were approximately one hour and respondents were asked questions on three broad themes: (1) how they become a practitioner in the complimentary and alternative health industries and the evolution of the organization within which they were affiliated; (2) their views on the question of what is "health" and how this may or may not have shifted in recent decades; and (3) their views on the part of the city in which they practice, and how it has changed over time.[1] A general guide to the interview questions is included in Appendix B below. However, I did tailor the questions to the specific discipline and expertise of each respondent. A copy of the letter of invitation to participate is included in at Appendix C. Responses to these questions were analyzed with three key questions in mind:

(1) What kind of goals and/or problematizations of health and health care led the practitioner to their chosen health discipline?

(2) Within the respondents' discourses and theories about what health is and how it is obtained, what kind of knowledge about life and health is produced? What, if anything are the features or dimensions of its spatial imaginary?

(3) What kinds of subjects are assumed or produced through the discourses and practices in question?

These questions parallel the questions that guided the inquiry into historical policy events shaping the advent of Medicare and the rise of the New Public Health in Canada.

In order to supplement interview data pertaining to the changing landscape in the area, I consulted two other main sources. First, using City of Toronto Business Directory listings since the 1980s I investigated the changing commercial landscape, with a particular emphasis on the place of health and wellness services and organizations. This data is presented, in summarized form, in Tables 6.1 and 6.2 on pages (nm) in Chapter 6. Second, I

[1] For a copy of the interview questions, please see Appendix C

used the addresses of currently existing health and wellness organizations to do a more targeted search through the directory listings to see what kinds of organizations occupied the addresses of current organizations in the past, looking as far back as the late 1980s. In order to obtain information on current health and wellness organizations, I spent many hours walking in the neighbourhoods, making note of the physical locations of current health and wellness organizations, taking pictures and making notes and observations pertaining to the discursive presentation of products and services there-in.

A few final words on how I have incorporated interview transcript material. I have made some changes to the transcription of interview data. While most respondents (9 of 11) waived or partially waived their right to confidentiality (see p. 360 of Appendix D, below) I choose nevertheless to take this additional measure to protect equally the anonymity of all respondents for two reasons. First, since the area of the study is relatively small, as is the group of possible participants, protecting the anonymity of each better protects the anonymity of all. Second, in quoting people at some length in this chapter, my aim was to highlight continuities, tensions and discontinuities with broader processes. The aim was not to single out the attitudes or behaviors of specific individuals. Thus, additional protections of anonymity in this way allow us to focus on the broader process and not on the words of specific individuals. It is also for this reason that all interviews are cited in the bibliography as "anonymous interview #[number], [date]. [in person/phone]"

I made two main types of changes to quotations that will help to protect the anonymity of the speakers. First, I altered or omitted specific spatial or geographic details that may make a speaker identifiable to others. In cases of a change, rather than a complete omission, I took a specific detail and replaced it with a generic one. To use a made up example, if a speaker said, "it's a really nice shade of green", I made this more generic by

writing "it a really nice colour". The second type of change that I made was to remove unnecessary words that reveal persons habits of speech. For example, where people characteristically use certain turns of phrase (i.e. frequently punctuating sentences with "right?" or using certain types of transition phrases: "and so then it becomes" "and so then it happens" "kind of" "so like" and so forth.) I have omitted these in all cases where the sense of what is being conveyed can be maintained. In the rare case where continuity would be lost, I have replaced a characteristic speech habit with something more generic.

Appendix B: Interview Questions (General Schedule)

Possible Interview Questions: CAM Health Organizations: West Toronto.

1) I'd like to begin by asking a few questions about your background. First, how long have you worked at _____? What would be your current capacity? How and when did you first get interested in this line of work/activity? How long have you worked or lived in this part of the city? And what drew you here?

2) Could you tell me a bit about the history of your organization? How did it come into being, how long have you been in this space, what kinds of relationship you have with agencies and businesses in the area, that kind of thing?

3) Do you know what was here before you/your organization? Thinking historically, do you have any sense of how this area has changed over time? What kinds of organizations have moved out or shut down? Which ones have moved in?

4) What are the goals of your organization? Could you talk a bit about the mission, vision, and so forth? What are the people (clients or patients?) you treat here expected to gain from your services?

5a) [For health practitioners] What would be the most predominant services sought out by clients? How many clients use this service, and what would be the predominant age cohort, gender, etc.? Are most people covered by private health plans? Is insurance coverage or insurability of services important to the viability of the work you do?

5b) [For yoga instructors] Why do people practice yoga? How many clients would you say you/your organization has, and what would be the predominant age cohort, gender, etc.? What are the current payment options for yoga? In the future, would you like to see this change or expand? Is yoga affordable?

6) Could you speak a bit about your view of health and wellbeing and conversely of ill-health? What do these things mean in your area of work in terms of challenges to health and wellbeing and how these can be solved or addressed? Also, thinking historically, would you say that there have been any major shifts in how "health" is understood more generally (i.e. social or political shifts) over the past 30 or so years? Similarly, would you say that there have been shifts in how people care for health? If so what would you say has been driving such changes?

7) Turning to the wider governmental framework, would you have an thoughts on how health professions in Ontario are regulated? For instance, today it is the case that some health related professions are provincially regulated while others are not. Would this matter in your line of work? Is it appropriate, etc?

8) Would municipal licensing have a bearing on health services in this area, in terms of zoning etc.? Would this be an area that you have any familiarity with? How does municipal licensing impact on the work you/your organization do?

9) Is there anything that you would like to add to what you have already said, or that you would like to emphasize?

10) Are there any internal documents that you could share with me? Such as pamphlets, or annual reports for example? Is there anyone you know that you think would be important for me to contact for this research? Could you share their name with me?

11) Before we finish, I would like to go over how I will verify this information with you. Within one week from today, I will prepare a summary of the interview and show it to you, so that you can verify that I have correctly represented what you have said. The summary will be the basis of how I incorporate your interview into my dissertation. If there is something that you think I have not accurately represented or, that you would like to change for some other reason, you may do so at that time. If you are happy with the summary, we can leave it as it is.

Thank you for your time.

Appendix C: Letter of Invitation (email)

Dear _____,

My name is Jessica Parish, and I am a PhD Candidate in the Department of Political Science at York University. I am conducting research into the changing health landscape in Toronto. In particular, I am interested in the growth of complementary and alternative health organizations and providers in the West Toronto area.

I am contacting you because I understand that you are _____. I would like to request an interview with you, to gain insights into the work you do as _____.

Would you be available to participate in an interview with me, of approximately one hour in length, on either ____ or ____? If neither of these days works for you, but you are interested, please feel free to suggest an alternate date or dates and a time that would be convenient for you.

For your information, I have attached two documents pertaining to the research. The first document contains a list of possible interview questions. Please note that this is a generic list, and is only intended to give an idea of the kinds of questions I am interested in asking. Not all participants are expected to answer all questions, and I may tailor the list of questions to particular interviews. Further, interview participants are encouraged to raise issues that these questions do not specifically address.

The second document is an informed consent form, and it contains further details about my research. It also affirms this research has been approved by the Research Office at York University, and it outlines my responsibilities for the care of any information that you may choose to share with me as a researcher.

I look forward to your response and to the opportunity to discuss your work with you.

If I do not hear from you within one week from today, I will follow up with you either by phone or by email.

Sincerely,

Appendix D: Letter of Information (Informed Consent)

[Date]

[Name of Researcher
Institutional affiliation
Address, and contact information]

[Name of Supervisor
Institutional affiliation
Address, and contact information]

Dear [Name],

My name is Jessica Parish. I am a PhD candidate at York University working on a dissertation provisionally entitled *Healthy Desires: Nature, Ethics and the Politics of Health Alternatives in Canada*. The aim of this project is to document and analyze the rise in popularity of health practices and professions currently considered by Health Canada to be forms of Complimentary and Alternative Health Care (CAHC) and to ascertain how these processes relate to health services at the local and neighbourhood level, with Parkdale serving as my local research focus.

My primary research questions are as follows:

> 1) How has the broad field of complementary and alternative health shaped official definitions of health and wellness?
> 2) How have complementary and alternative health care definitions of health and wellness shaped governance practices and processes at the local, provincial and national level?
> 3) To what extent have the above transformations altered the street-level context of Parkdale over the last several decades?

I am contacting you because I am interested in the work you do in your field(s) of health. Any knowledge about, or perspectives you have gained in your professional experiences and observations regarding the above outlined areas would be of value to the research project. I would therefore be interested in having the opportunity to sit down with you and ask you some questions, in the form of an open-ended interview. This would take somewhere between 45 and 90 minutes of your time, and would be scheduled at a time and location of your choosing; alternatively, if it is not possible to meet face to face, the interview could take place over the telephone.

Should you consent to an interview, I will do all that I can to ensure that you are comfortable. If there is a question that I ask that you do not want to answer, you are under no obligation to do so; nor are you under any obligation to provide me with an explanation for why this is. We will simply move on to the next question. Similarly, you are free to terminate the interview at any time, with no explanation required. If, at any time, you decide that you do not wish to participate in the research, or that you do not wish to respond to any particular question or questions, this will not

affect your relationships with the researchers, York University, or any other group associated with the project.

The interview can be conducted with or without audio recording; again this depends on your preferences. After we have completed the interview I will write up my notes, and/or transcribe the audio recording. At this time I will send my notes to you for verification. If there is anything that you feel is inaccurate in how I have recorded our conversation, you may ask for it to be changed at this time. If for any reason you decide that you no longer wish to be a part of this study you may contact me to have your information withdrawn and returned to you or destroyed, at any time prior to the publication of the study in 2016. Baring the aforementioned situation all data collected will be securely stored for 5 years after the date of the dissertation defense. After this time all data will be destroyed by deletion of all records, both hard and electronic versions. All electronic data will be stored on password protected or encrypted hard drives and both electronic and hardcopy data will be stored in a locked drawer in my office. The interview and any recordings or field notes derived from it will be used for research purposes only. Findings may be published in report, article, or book form, or presented at public meetings of scholarly associations.

The confidentiality of participants will be protected to the fullest extent possible by law. If you choose to participate in this research, your privacy will be protected and your name will not be released to anyone. Information obtained as part of confidential interviews will be complied and reported on in such a manner so that individual respondents cannot be identified. However, if you would prefer to have your name and/or the name of the organization of which you are a member, included in the publication of any papers or reports which are produced from this research, you may choose to waive this confidentiality, in whole or in part, in a section of this letter below. Similarly, interviews will be audio recorded only if you give your express written consent in the section of the form provided for this.

I do not foresee any direct benefits to you in participating in the research; however there may be some indirect benefits. In particular, the completed study may help participants to better understand the broader social health 'story' that the field in which they work is implicated. Second, because CAHC represents a growing field of health care practice in Canada, a more comprehensive and politically informed understanding of the contributions these practices make to the health of Canadians is valuable.

I do not foresee any discomfort or risks from your participation in the research.

If you are interested in receiving a copy of the research, in whole or in part, you may contact me at the email address above. I expect to have a full final draft of the dissertation prepared by January 2016.

Professor Karen B. Murray is supervising the study, which has been approved by the Review of Ethics Board at York University in accordance with the Government of Canada Tri-council Policy Statement on the Ethical Conduct of Research. This statement is publically available and can be viewed at:

http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/. 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, at York University. They can be reached by telephone at [number] or via e-mail at [email]. You may also contact me and/or Dr. Murray at the email addresses provided above.

If you consent to participating in this research, please sign and date this form in the space provided below. If you are returning this form electronically, please write 'I consent to participate in your research' in the text of your email, with this form attached.

A. Consent to have the interview audio-recorded:

I, _____, agree to have this interview audio-recorded: [ ].

B. Option to waive confidentiality with regard to reporting your name in research results:

I, _____, agree to waive confidentiality with respect of the reporting of my name in the research results as having participated in this study: [ ].

C. Option to waive confidentiality with regard to reporting the name of the organization with which you are affiliated as having had one of their members participate in this study:

I, _____, agree to waive confidentiality such that the name of the organization to which I am affiliated be included in the reporting of research results as having had one of its members participating in this study: [ ].

Thank you in advance for your time.

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.

Signed (Participant) _____ Date _____

Signed (Researcher) _____ Date _____

*****Oral Consent Statement Follows*****

Oral Statement

Hello [insert name],

My name is Jessica Parish. I am a PhD candidate at York University working on a dissertation provisionally entitled *Healthy Desires: Nature, Ethics and the Politics of Health Alternatives in Canada*. The aim of this project is to document and analyze the rise in popularity of health practices and professions currently considered by Health Canada to be forms of Complimentary and Alternative Health Care (CAHC) and to ascertain how these processes relate to health services at the local and neighbourhood level, with Parkdale serving as my local research focus.

I am required to obtain your consent for an interview. If a telephone interview is proposed, I will read this consent form to you over the phone prior to commencing the interview and obtain your consent orally. Afterward, I will send you a confirmation e-mail verifying your consent, which will include this oral statement for your records, which will also include my contact details and contact information for York University's Research Ethics Office. If a face-to-face interview is being conducted, I will provide you with a copy of this consent form for you to read and sign prior to commencing the interview.

My primary research questions are as follows:

> 1) How has the broad field of complementary and alternative health shaped official definitions of health and wellness?
> 2) How have complementary and alternative health care definitions of health and wellness shaped governance practices and processes at the local, provincial and national level?
> 3) To what extent have the above transformations altered the street-level context of Parkdale over the last several decades?

I am contacting you because I am interested in the work you do in your field(s) of health. Any knowledge about, or perspectives you have gained in your professional experiences and observations regarding the above outlined areas would be of value to the research project. I would therefore be interested in having the opportunity to sit down with you and ask you some questions, in the form of an open-ended interview. This would take somewhere between 45 and 90 minutes of your time, and would be scheduled at a time and location of your choosing; alternatively, if it is not possible to meet face to face, the interview could take place over the telephone.

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I do not foresee any direct benefits to you in participating in the research; however there may be some indirect benefits. In particular, the completed study may help participants to better understand the broader social health 'story' that the field in which they work is implicated. Second, because CAHC represents a growing field of health care practice in Canada, a more comprehensive and politically informed understanding of the contributions these practices make to the health of Canadians is valuable.

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Professor Karen B. Murray is supervising the study, which has been approved by the Review of Ethics Board at York University in accordance with the Government of Canada Tri-council Policy

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http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/Default/. 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, York University. They can be reached by telephone at [number] or via e-mail at [email].You may also contact me and/or Dr. Murray at the email addresses provided above.

If you consent to participating in this research, please sign and date this form in the space provided below. If you are returning this form electronically, please write 'I consent to participate in your research' in the text of your email, with this form attached.

C. Consent to have the interview audio-recorded:

I [insert name] agree to have this interview audio-recorded: [ ].

D. Option to waive confidentiality with regard to reporting your name in research results:

I [insert name] agree to waive confidentiality with respect of the reporting of my name in the research results as having participated in this study: [ ].

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I [insert name] agree to waive confidentiality such that the name of the organization to which I am affiliated be included in the reporting of research results as having had one of its members participating in this study: [ ].

Thank you in advance for your time.

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.

Signed (Participant) _____ Date _____

Signed (Researcher) _____ Date _____