

**Early efforts addressing the social determinants of health by
Ontario health units (2000-2009): an application of
Kingdon's multiple streams theory**

by

Brian Hyndman

A thesis

presented to the University of Waterloo

in fulfillment of the

thesis requirement for the degree of

Doctor of Philosophy

in

Public Health and Health Systems

Waterloo, Ontario, Canada, 2017

© Brian Hyndman 2017

Examining Committee Membership

The following served on the Examining Committee for this thesis. The decision of the Examining Committee is by majority vote.

External Examiner	Dr. Benita Cohen Associate Professor, College of Nursing Rady Faculty of Health Sciences University of Manitoba
Supervisor	Dr. John Garcia Professor of Practice and Associate Director Professional Graduate Programs, School of Public Health and Health Systems University of Waterloo
Internal Member	Dr. Samantha Meyer Assistant Professor, School of Public Health and Health Systems University of Waterloo
Internal-external Member	Dr. Heather MacDougall Associate Professor, Department of History University of Waterloo
Other Member(s)	Dr. Martin Cooke Associate Professor, Department of Sociology and Legal Studies University of Waterloo

Author's Declaration

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Actions to reduce health inequities by addressing external contributory factors, which are commonly referred to as the social determinants of health (SDH), have emerged as a recommended focus of public health practice. While facilitators and barriers to SDH-focused public health practice have been assessed at the national level, comparatively little research has examined the factors affecting the initiation of SDH-focused initiatives by local public health authorities. This study addresses this knowledge gap through a multiple case analysis of five Ontario health units that launched SDH-focused initiatives during a timeframe characterized by the absence of an explicit provincial mandate for this work. Collectively, these organizations also advocated for the inclusion of SDH-focused actions into the legally mandated functions of Ontario health units. Twenty in-depth, semi-structured interviews were conducted with the current and former leadership of these health units, health unit staff and community allies. Interview data were supplemented by primary documentation. Data collection and analysis were guided by multiple streams theory, a policy agenda setting model maintaining that policies arise through the efforts of policy entrepreneurs capitalizing on 'windows' for policy change created by the convergence of two or more independent streams: problem, politics and policy. The data demonstrated moderate to strong support for the theory as a predictor of the conditions enabling the initiation of SDH-focused activities, with evidence of a full or partial stream convergence in the majority of cases (5-6), depending on how one defines the parameters of the policy stream. The independence of the streams was upheld at the local level. However, the collaboration for a province-wide SDH standard was characterized by the inter-dependence of the politics and policy streams. The integration of open coding with theory-based coding in the data analysis enabled the identification of key explanatory variables not accounted for by multiple streams theory. These included geography, historical antecedents, and community culture. Elements of two alternative policy theories, the advocacy coalition framework and the punctuated equilibrium framework, also displayed predictive utility. Implications for the study of theory, practice and methods are discussed, as are strengths and limitations, and priorities for future research.

Acknowledgements

I want to begin by acknowledging the current and former public health unit professionals and their community partners who contributed their time and insights to this study. Without their participation, I would not have been able to proceed with my dissertation. They demonstrated a deep, unwavering commitment to reducing health inequities by applying a social justice lens and through their actions showed that they truly cared about the health and well-being of their communities. They provided insightful reflections about their organizations and community contexts. In addition, they took the time to delve through their personal and organizational archives to provide me with the primary documentation that was essential in enabling me to develop fulsome case descriptions and test my analytic propositions. I hope that I have depicted their work in a way that provides a greater degree of clarity about the myriad of factors affecting the adoption and implementation of public health actions addressing the social determinants of health. I also hope that this study will provide an impetus for further research that will guide the development of public health policies, protocols and practices for reducing health inequities.

John Garcia, my supervisor throughout my PhD journey, has become a valued colleague and friend. Over the past five years, he has guided my progress through insightful questions, encouragement, constructive criticism and timely suggestions. John is a very busy individual with a myriad of important roles and responsibilities, both at the University of Waterloo and within the broader public health systems in Ontario and Canada. But no matter how little blank space he has in his day planner, he always finds the time to help and support his students. John is dedicated to making a positive difference as a teacher, administrator, and public health advocate, and has had great impact as a result. I have learned more from him than I can possibly express within the confines of an acknowledgements section. Going forward, I aspire to model my future roles after his example - especially mentoring others to make optimal use of their skills and abilities.

It was a true pleasure working with my thesis advisory committee. Martin Cooke provided helpful questions and insights throughout my comprehensive examination and thesis processes. His extensive knowledge of social demography led me to consider the role of underlying community conditions in ways that had not occurred to me, and I think my dissertation is a better product as a result. Samantha Meyer gave me helpful feedback on successive drafts of my thesis and invaluable advice for analyzing my data. In particular, an article she co-authored, which lays out a pragmatic approach to combining the benefits of theory-driven and grounded theory approaches to qualitative data analysis, was instrumental in guiding the development of my coding frame. Heather MacDougall, the internal/external member of my thesis committee, provided incisive questions and comments about critical aspects of my study. Her book on the history of the Toronto Board of Health, which I read some years prior to undertaking my PhD, first piqued my interest in the importance of history as a discipline for better understanding and analyzing current issues in the realm of healthy public policy. Benita Cohen, my external

examiner, is an accomplished and respected leader in research focused on strengthening public health capacity to address and reduce inequities in health. It was indeed my honour to be examined by such a diverse, knowledgeable and supportive group of public health experts.

I also want to acknowledge the help and support I received from the administrative staff in the School of Public Health and Health Systems and the Faculty of Applied Health Sciences at the University of Waterloo. In particular, I wish to thank Trevor Bain, Krista Nicol, Tracy Taves, Carol West-Seebeck, and Tracie Wilkinson, who assisted me with the timely completion of all requisite paper work, provided me with logistical and technical support for my comprehensive and thesis defenses, and guided me through the myriad of bureaucratic hurdles that PhD students are expected to surmount. In addition, I want to acknowledge the financial support I received through successive RA-ships at the Propel Institute for Population Health Impact as well as the Jean and William Leach Memorial Scholarship, the Queen Elizabeth II Graduate Scholarship in Science and Technology, and the Applied Health Sciences Senate Graduate Scholarship - all of which helped to ensure that I had equitable access to the social determinants of health during the completion of my doctorate.

Completing a doctoral dissertation can be a socially isolating experience, necessitating days and weeks of ‘alone time’ in front of a computer screen. Fortunately, I had the benefit of social support from a diverse and valued network of friends. I hope I don’t risk losing a friend or two by not naming them all here. But I do want to acknowledge the encouragement I received from Irene Lambraki and Paula Neves, both of whom successfully completed their PhDs and gave me the confidence to believe that I, too, could reach the finish line. I also want to acknowledge the influence and support of my friend Lorraine Telford. Many years ago we co-developed a logic model focused on strategies for ‘taking the handle off the poverty pump’ (apologies to John Snow). This work convinced me that public health units have a critical role to play in addressing the social determinants of health and has served as a foundation for my subsequent research and capacity building activities.

One of the sad aspects of completing a doctorate in mid-career is that some of the people who were instrumental in supporting you are no longer around to celebrate your achievement. There are a few who come to mind, but two stand head and shoulders above everyone else. This thesis is dedicated in loving memory of June Evangeline Roedding and Keith Barclay Hyndman, my parents and caregivers, who gave me my name, encouraged me to put my talents to good use, believed in my ability to make a positive difference, and taught me the simple lessons of hard work, perseverance, fairness, and treating others the way you would like to be treated that have helped me along my path.

Table of Contents

	Page
Examining Committee Membership	ii
Author's declaration	iii
Abstract	iv
Acknowledgments	v
List of Figures	x
List of Tables	xi
List of Abbreviations	xii
1. Introduction	1
1.1 The multiple streams theory of policy change	3
1.2 Application of the multiple streams theory to SDH issues	6
1.3 Strengths and limitations of the multiple streams theory and its application to SDH issues	9
2. Study Rationale and Objectives	14
3. Research Questions and Analytic Propositions	17
3.1 Research questions	17
3.2 Analytic propositions	17
4. Methodology	20
4.1 Rationale for case study methodology	20
4.2 Rationale for selection of cases	22
4.3 Data collection	24

Table of Contents (Continued)

	Page
4.4 Framework guiding data collection and analysis	28
4.5 Data collection and analysis	31
4.6 Limitations of methodology	32
5. Setting the Context Part I: A Historical Overview of SDH-Focused Public Health Initiatives in Ontario (1910-2000)	34
6. Setting the Context Part II: Ontario in 2000	45
7. Local Public Health Unit Actions Addressing the SDH in Ontario (2000-2009)	50
7.1 Peterborough City-County Health Unit	50
7.2 Leeds, Grenville and Lanark District Health Unit	74
7.3 Region of Waterloo Public Health	89
7.4 Huron County Health Unit	108
7.5 Sudbury and District Health Unit	126
8. Towards a Standard Approach to SDH-Focused Health Unit Actions across Ontario Health Units (2005-2009)	144
9. Discussion	165
9.1 Support for multiple streams theory as a predictor of SDH policy initiatives by Ontario health units	166
9.2 Key factors outside of multiple streams theory	191
9.3 Implications for research, policy and practice	200
10. Epilogue: Key Developments Since 2009	209

Table of Contents (Continued)

	Page
References	214
Appendix A: Interview Questions for Medical Officers of Health	235
Appendix B: Interview Questions for Public Health Unit Staff	241
Appendix C: Interview Questions for Community Partners/Allies	247
Appendix D: Toronto Charter for a Healthy Canada	249
Appendix E: Determinants of Health Prioritization Tool (HCHU)	253
Appendix F: SDHU BOH Determinants of Health Position Statement (2005)	254
Appendix G: Determinants of Health - Developing an Action Plan for Public Health - Joint aLPHa-OPHA Conference Session, November 22-23, 2005	257
Appendix H: Draft Proposed General and Program Standards for the Social Determinants of Health (2005)	259
Appendix I: Ontario Public Health Association (OPHA) Resolution on the Determinants of Health (2005)	261
Appendix J: Determinants of Health as a Mandatory Public Health Program Association of Local Public Health Agencies Resolution (2005)	262
Appendix K: Determinants of Health Report - Information Meeting with Ministry Representatives (January 15, 2007)	264
Appendix L: Public Health Goals, Activities and Indicators to Measure Progress Related to the Social and Economic Determinants of Health (for Proposed SDH Program Standards)	265

List of Figures

	Page
Figure 1: The Multiple Streams Theory of Policy Change	4
Figure 2: Application of Multiple Streams Theory to SDH-Focused Public Health Action: A Proposed Model	30

List of Tables

	Page
Table 1: List of Key Informant Interview Respondents	26
Table 2: Sensitizing Concepts for Development of Data Collection Instruments	29
Table 3: PCCHU Case Summary and Degree of Convergence Between Streams	73
Table 4: LGLDHU Case Summary and Degree of Convergence Between Streams	88
Table 5: RoWPH Case Summary and Degree of Convergence Between Streams	107
Table 6: HCHU Case Summary and Degree of Convergence Between Streams	125
Table 7: SDHU Case Summary and Degree of Convergence Between Streams	143
Table 8: Ontario Case Summary and Degree of Convergence Between Streams	164
Table 9: Summary of Local and Provincial Cases by Analytic Propositions and Key Components of MST	190

List of Abbreviations

aLPHA	Association of Local Health Agencies, a not for profit organization representing the interests of Ontario’s 36 Boards of Health and Public Health Units.
AMO	Association of Municipalities of Ontario, a not for profit organization representing the interests of Ontario’s municipalities.
BOH	Board of Health.
COMOH	Council of Medical Officers of Health, a subgroup of the Association of Local Public Health Agencies representing the interests of Medical Officers and Associate Medical Officers of Health at Ontario’s 36 public health units.
HCHU	Huron County Health Unit.
HDPED	Health Determinants Planning and Evaluation Division, a multi-disciplinary Division established by the Waterloo Region Community Health Department (later re-named Region of Waterloo Public Health) that led the implementation of SDH-focused health unit initiatives from 1999 till its dissolution in 2010.
LGLDHU	Leeds, Grenville and Lanark District Health Unit.
MHPSG	Mandatory Health Program and Services Guidelines, the document specifying the legislated program and service requirements of Ontario’s health units (in effect from January 1, 1998 to December 31, 2008).
MOH	Medical Officer of Health.
MOHLTC	Ministry of Health and Long-Term Care.
MST	Multiple Streams Theory.
OPHA	Ontario Public Health Association, a not for profit organization representing the interests of public health professionals.
OPHS	Ontario Public Health Standards, the document specifying the legislated program and service requirements of Ontario’s health units (in effect since January 1, 2009).

List of Abbreviations (Continued)

PCCHU	Peterborough City-County Health Unit.
RoWPH	Region of Waterloo Public Health.
SDH	Social Determinants of Health.
SDHC	Social Determinants of Health Committee, an inter-departmental committee developed by the Peterborough City County Health Unit that guided its SDH-focused initiatives from 2003 till its dissolution in 2012.
SDHU	Sudbury and District Health Unit.

1. Introduction

The reduction of health inequities as a public health priority is underscored by decades of research linking lower positions on socio-economic hierarchies - as measured by income level, education or occupational status - to a greater risk of premature morbidity and mortality (Marmot, 2004; World Health Organization, 2008). While some inequalities in health outcomes are attributable to biological/genetic variations, others are clearly related to conditions in the external environment that lie outside the control of the affected individuals. In these instances, the uneven distribution of morbidity and mortality are unnecessary and avoidable as well as unfair and unjust, such that the resulting health inequalities produce inequities in health status (Whitehead, 1992).

Actions to reduce health inequities by addressing these contributory factors, which are collectively referred to as the social determinants of health (SDH), has emerged as a recommended focus of public health practice. The extent to which public health authorities have embraced this challenge, however, is mixed, with multi-jurisdictional reviews revealing comprehensive programmatic and policy responses in some regions (e.g., the Nordic countries) and more sporadic, piecemeal approaches in others, including Canada (Raphael 2012).

In Ontario, Canada's largest province, local public health authorities (i.e., municipally and regionally-based public health units) exercise a considerable degree of influence in defining and addressing health issues at the community level. However, with the exception of some Toronto-based initiatives (see Section V for additional details), Ontario's public health units did relatively little to address the SDH until the opening decade of the present century (2000-2009).

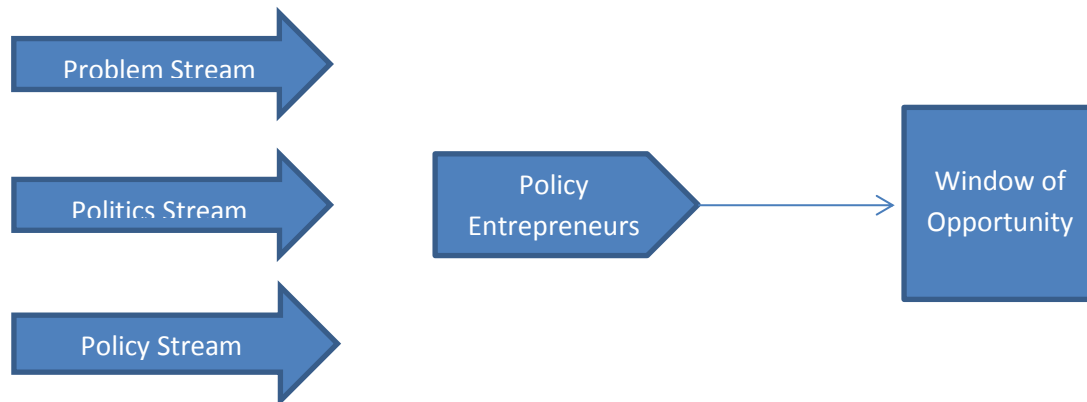
During this time, several health units initiated activities focused explicitly on health inequities and the SDH. These included: the development of community health status reports on equity and SDH issues; the creation and dissemination of best practice documents for planning and implementing equity-focused programs, SDH-focused planning processes undertaken in partnership with other community agencies, media campaigns raising community awareness of the SDH, and the creative use of provincially funded programs (e.g., the Ontario Heart Health Program) to implement activities addressing poverty and food security (Raphael, Curry Stevens and Bryant, 2008). Collectively, these health units also collaborated in a two-year advocacy effort for the inclusion of a SDH standard in the document specifying the legally mandated programs and services of Ontario health units (Lefebvre et al., 2006). While this effort to explicitly integrate the SDH into the mandate of Ontario health units proved to be unsuccessful, steps were taken to expand the scope of health unit activities aimed at reducing health inequities. Specifically, with the introduction of the Ontario Public Health Standards (OPHS), which replaced the Mandatory Health Programs and Service Guidelines in January 2009, a focus on health inequities was integrated into the mandates of boards of health. The OPHS Foundational Standard directs Ontario's Boards of Health to plan and deliver interventions to meet the needs of priority populations (Ontario Ministry of Health and Long Term Care, 2008). A commitment to action on reducing health inequities is embedded in the introductory section of the OPHS, which notes that "addressing the determinants of health and reducing health inequities are fundamental to the work of public health in Ontario. Effective public health programs and services consider the impact of determinants of health on the achievement of public health outcomes" (2008, p. 2).

While facilitators and barriers have been assessed at the national level (Petticrew et al, 2004; Collins and Hayes, 2007; Raphael, Curry Stevens and Bryant, 2008), relatively little work has been done to identify the factors favouring and impeding the introduction of SDH-focused initiatives by local public health authorities. The application of policy development theories have the potential to broaden the scope of SDH-focused public health practice by elucidating the mechanisms by which some policy issues and alternatives gain more traction in some settings than others (Exworthy, 2008; Embrett and Randall, 2014). Multiple streams theory (MST), a policy agenda setting model developed by Kingdon (1995, 2011), provides a useful framework for analyzing the factors contributing to policy decisions at the community level. The following sections present the rationale for applying this theory to better understand the decision making processes underlying the adoption of SDH-focused public health policy at both the provincial and local levels in Ontario.

1.1 The multiple streams theory of policy change

Initially developed in 1984 to explain policy making in the tri-partite system of government adopted by the United States, MST focuses on how issues get onto the policy agenda and how proposals are translated into policy options (Kingdon, 2011). Specifically, Kingdon maintains that policy ‘windows’, optimal opportunities for policy change, open and close through the coupling or decoupling of three streams: problem, politics and policy. A diagram illustrating the main components of the model is provided in Figure 1.

Figure 1: The Multiple Streams Theory of Policy Change



Issues, such as inequitable access to the SDH, only become defined as **problems** when they are perceived as such. Kingdon (2011) identifies three conditions through which issues may be recognized as problems:

1. **Indicators** arising from the publication of ‘evidence’ such as research studies or official inquiries;
2. **Focusing events**, such as crises or critical incidents in a community or other jurisdiction;
3. **Feedback** about the operation of existing programs/policies linked to the issue (via the media or public opinion).

The **policy** stream encompasses the range of intervention options that researchers, decision makers, advocates and others put forward in response to identified problems. Kingdon (2011) notes that - for any policy to be enacted - it must meet the minimum thresholds of technical feasibility, congruence with dominant socio-political values, and anticipation of future constraints of the policy under consideration.

Kingdon (2011, p. 201) describes a “long softening up process” as critical for policy change. Opportunities provided by the opening of policy windows pass quickly and can be missed if proposals have not undergone a long gestation process before the window opens.

Last, the **politics** stream refers to both political events (e.g., elections) and the lobbying, negotiation and coalition building activities of key interest groups and power bases. Unlike the policy stream, which relies on persuasion to achieve consensus, decisions in the political stream arise from bargaining. In practice, this often involves making concessions or compromising from ideal positions to gain wider acceptance (Kingdon, 2011).

Kingdon argues that the three streams operate independently of one another. But at critical junctures, the streams will intersect (e.g., increased recognition of a problem coincides with a viable solution and a political climate favouring action). This, in turn, opens up a **policy window** that can facilitate change. Policy windows occur sporadically, and may only remain ‘open’ for short time spans. Accordingly advocates promoting specific policy or program options, defined by Kingdon as the “**policy entrepreneurs**”, must be cognisant of policy windows and act quickly before the opportunity passes by (Kingdon, 2011).

The convergence of the three streams at a given time is referred to as **coupling**. Streams may be coupled by chance factors, political developments (e.g., the election of a new government), organizational cycles (e.g., staff turnover), or the actions of **policy entrepreneurs**. Conversely, de-coupling may also occur if/when conditions are not met (e.g., a problem recedes as another issue assumes greater importance). Kingdon also refers to **partial couplings**, such as policy solutions to a recognized problem in the absence of a supportive political climate. However, partial couplings are less likely to rise on the policy making agenda: the complete

coupling of all three streams enhances the odds that an issue will be addressed by policy makers (Kingdon, 2011).

Kingdon attributes the effectiveness of policy entrepreneurs to three key attributes. The first is **claim to a hearing**, the recognized authority/credibility of the entrepreneur to speak on behalf of others. The second attribute encompasses **political connectedness and negotiating skills**. The third attribute is **persistence**, meaning that actors investing greater amounts of time and resources to promote their ideas in multiple fora have a greater likelihood of capitalizing on an ‘open window’ to advance their policy agenda (Kingdon, 2011).

1.2 Application of the multiple streams theory to SDH issues

Since its creation, the MST has been extensively applied to a range of policy scenarios. A meta-review of MST applications by Jones et al (2016) identified 311 empirical applications of the MST published between 2000 and 2013, with studies conducted in 65 countries on 22 different policy areas, across all levels of government.

Throughout successive editions of his book describing his theory, Kingdon provides a number of examples illustrating how the opening of policy windows through the convergence of streams has influenced the success or failure of key American policy initiatives. For example, the most recent edition of his book contrasts the 2010 passage of the *Affordable Care Act* (aka Obamacare) with the failed attempt to expand health care coverage under the Clinton administration in 1993-94. Kingdon attributes the passage of the former to a policy window resulting from a convergence of factors in each stream: growing recognition of the problem of rising health care costs in the wake of severe economic downturn; the emergence of a 60-seat, filibuster-proof Democratic majority in the 2008 U.S. Senate elections (a political asset

unavailable to President Clinton in 1994); and the emergence of a consensus among key policy entrepreneurs that achievable reform would centre upon a mandate for individual coverage while leaving current government programs and private insurance providers in place (Kingdon, 2011).

Exworthy (2008) notes that the multiple streams model is particularly relevant for the study of health inequities and the SDH, given the failure of many SDH-focused initiatives to reach the policy agenda in spite of mounting evidence and policy proposals. However, it appears that only a limited number of studies have systematically applied Kingdon's model as a means of analyzing efforts to get SDH on the policy agenda, a finding supporting the aforementioned tendency of SDH literature to focus on advocacy rather than policy development and the scant use of policy analysis theory among SDH researchers (Embrett and Randall, 2014). A review of the extant literature conducted in 2015 to guide the preparation of the proposal for this study found only three applications of multiple streams focused on SDH-related policy making in the public health sector.

First, an application of the model to assess the characteristics of policy entrepreneurs and the emergence of policy windows in ten European Healthy Cities projects was undertaken by DeLeeuw (1999). Through a combination of key informant interviews and focus groups, over 300 project stakeholders were asked to situate the evolution of their projects within the key streams of Kingdon's theory and discuss the role of policy entrepreneurs in capitalizing on policy windows in their respective communities.

Six of the ten cities recognized Kingdon's streams and were able to articulate how they impacted on policy modifications affecting their vision of a Healthy City. Two cities described how they had effectively leveraged the opening of policy windows to effect change: the creation

of a community action centre in Horsens (Denmark) and funding for intersectoral projects in Vienna. Policy entrepreneurs were found to be present in all of the cities, although their degree of effectiveness varied. The cities reporting success in acting on open policy windows were also cities that institutionalized their entrepreneurial activities (DeLeeuw, 1999).

The second application involved a cross-sectional study of nine child health promotion initiatives in three Swedish municipalities. Gulbrandsson and Fossum (2009) assessed the results of key informant interviews (N=50) and written documentation to identify statements related to policy windows and policy entrepreneurs. All of the conditions required to open a policy window (i.e., the problem, political and policy stream) were present in eight of the nine cases; only the policy stream was evident in the remaining case. The study also found that sheer persistence was the most common attribute of policy entrepreneurs, a finding consistent with Kingdon's notion of the long 'softening up' process needed to secure policy change.

In the third and final application, the multiple streams model was one of two theories selected to analyze the development of state-level health equity policies in Norway (Strand and Fosse, 2011). Similar to the earlier research by Gulbrandsson and Fossum (2009), Strand and Fosse utilized a case study approach combining interview data (N=8) with a content analysis of official government documents.

Strand and Fosse found that the agenda setting process for health equity played out in ways commensurate with Kingdon's concepts. Historically, health inequities were excluded from both the problem and political agenda out of strongly held convictions that Norway had attained a relatively egalitarian society. However, this sense of complacency was eroded by a widely publicized study pointing to large socio-economic health gaps that were not being addressed

(Mackenbach, 1997). This, in turn, led to the development of a 2003 government white paper outlining steps to reduce social inequalities in health. Strand and Fosse interpreted this development as a “partial coupling” since a lack of political will limited the scope of white paper interventions to lifestyle modification programs targeting disadvantaged groups. It took the subsequent (2005) election of centre-left coalition government, which came into power on promises to fight poverty and work for a more equitable society, to achieve a full coupling of the three streams and a more robust approach to addressing health inequities (Strand and Fosse, 2011).

1.3 Strengths and limitations of multiple streams theory and its application to SDH issues

The widespread use of MST is attributable to two key factors. First, it accounts for the stochastic aspects of policy making by emphasizing the importance of timing. Yet the MST does not imply that policy actors lack agency and are bound by the influence of independently flowing policy streams: rather, the MST provides a more empowering vision of policy change whereby entrepreneurs can influence the policy making process through acting on opportunities created by the coupling of streams (Weible and Schlager, 2016). A second key strength of the MST lies in its practicality. As Jones et al (2016) notes, the MST has intuitive appeal, can be easily explained to those without policy change expertise, and, with a comprehensive case study, can be readily applied without extensive methodological training.

There are, however, some identified limitations to the MST. Literature on the application of the theory identifies four key shortcomings.

One of the most frequently debated issues concerns the degree of ‘independence’ between the three streams. Kingdon maintains that each stream is independent, with its own rules and dynamics. It is only during open ‘windows’ of opportunity that the three streams interact, often through the strategic intervention of policy entrepreneurs. However, if this is the case, then to what extent can the three streams be considered independent? Mucciaroni (1992) contends that the windows would be better characterized as ‘interdependent’ rather than ‘independent.’ By criticizing this feature of Kingdon’s model, Mucciaroni does not suggest that it is ineffective in analyzing the policy making process; rather, he points to the need to improve the model by adding a dimension of interdependency between the streams.

Second, the MST has been criticized for under-valuing the role of learning from experience in explaining policy shifts. Other policy analysts have argued that policy change is dependent on a process of social learning by government, key stakeholders and the wider society (Sabatier, 1988; Hall, 1993). MST, by contrast, lacks a sufficient consideration of learning processes, especially the ways in which previous policy decisions have influenced current debates about policy options. This has led one critic to label the theory as “ahistorical” (Weir, 1992). However, it could be argued that this alleged shortcoming may arise from a widespread tendency to apply the theory in broad brush strokes - as a heuristic device rather than a tool for conducting analytic investigation. In his own applications of the theory, Kingdon consistently notes the role of antecedent conditions (e.g., the 1978 passage of Proposition 13, a measure limiting property tax increases in California, in shaping state and federal taxation policies over the ensuing decade).

Third, the components of the three streams model, while helpful in elucidating dimensions of policy making in a range of settings, do not always provide sufficient predictive utility in explaining the agenda setting process (Mucciaroni, 1992). For example, a study applying the model to climate change policy identified critical factors that were not fully captured by any of the three streams (Brunner, 2008). Kingdon (2011, p. 206) attributes these instances to the seemingly random nature of some policy decisions, noting that in spite of efforts to empirically explain and predict policy formation “*we still encounter considerable doses of messiness, accident, fortuitous coupling and dumb luck.*” It would thus appear that the famous “*laws are like sausages, it is best not to see them made*” quote, widely attributed to Bismarck, can be equally applicable to the evaluation of policy.

Lastly, with its emphasis on emerging issues and their role in agenda setting, the MST has been criticized for underestimating the importance of interests and networks. Networks of experts make a substantive contribution to agenda setting and policy change, especially in relation to policy-oriented learning (Bennett and Howlett, 1992; Zahariadis and Allen, 1995). Yet the MST explicitly notes the roles of networks and coalitions in shaping both the policy and politics stream, as well as the vital role of policy entrepreneurs (which is inclusive of collective entities) in maintaining a state of preparedness for the opening of policy windows (Kingdon, 2011).

As is the case with all policy development models, the MST presents an over-simplistic view. Distinctions between agenda setting, policy formulation and implementation are rarely clear cut; it is not always easy to distinguish intention from action (Exworthy, 2008). Some policy change theorists have argued in favour of a ‘garbage can’ approach that views the policy

making process as inherently disjointed and anarchic (Mucciaroni, 1992). However, the nihilistic nature of this viewpoint hinders the generation of insightful perspectives that can influence the policy making process. Other theorists maintain that studies combining several frameworks may provide a more complete explanation of policy change and its drivers (Cairney, 2007). However, this approach may increase the complexity of analysis, thereby limiting its utility in generating insightful propositions about the policy change process (Brunner, 2008).

The above-noted limitations of the MST, to some extent, appear to be premised on a rather cursory interpretation of the theory, which, as was noted earlier, manifests in a tendency to apply it as a heuristic device rather than a set of testable propositions. Throughout his book, Kingdon links his concepts to a range of hypotheses about the processes within each stream, processes that create and undo ‘couplings’, and general constraints on the agenda setting process. Moreover, Kingdon addresses the seemingly fortuitous nature of some policy decisions by noting features of each stream that mitigate against ‘random’ outcomes. For example, issues that are not supported by indicators, focusing events or feedback are less likely to be brought to the attention of government officials than conditions possessing these advantages (Kingdon, 2011).

Yet the aforementioned ideas are conspicuously absent in the extant literature applying the MST to account for policy decisions in a range of settings. Taken as a collective, these studies suffer from two key shortcomings.

First, as was noted earlier, the scope of application tends to be circumscribed, restricted to the basic, ‘bare bones’ components of the model (i.e., the three streams and, in some cases, the role of policy entrepreneurs). Each stream provides illustrative categories for the placement of critical milestones that appear to enable or inhibit policy change (e.g., the formation of a new

government). By ignoring key components of the theory, its predictive utility is severely diminished (Jones et al., 2016).

A second limitation arises from the failure of these studies to adequately describe the means by which selected concepts in the three streams theory were operationalized. This is a key omission of the relatively small number of studies that have used the MST to analyze the development of SDH-focused policy (DeLeeuw, 1999; Gulfranson and Fossum, 2009; Strand and Fosse, 2011). Specifically, these studies (at least in the published articles) do not specify the constructs/criteria employed to identify both the presence and interplay of theoretical components obtained through interviews, focus groups and/or document reviews. As a result, the links between the reported conclusions and the methods by which they were obtained is not always apparent.

The proposed study aims to address these limitations through the development of an operational framework for applying the three streams theory to assess the development of SDH-focused public health practice and policy at the local and provincial level. The framework comprises a set of research questions and a related set of analytic propositions that can serve as the basis for judging the theory's utility for predicting policy outcomes. The full rationale for the study is provided in the following section.

2. Study Rationale and Objectives

Despite widespread agreement that health equity and the SDH have received greater attention in recent years, there is growing concern that this momentum has not yet resulted in public health initiatives sufficient to reduce health inequities, and, if such initiatives are not robustly implemented in focused ways with demonstrable effects, SDH-focused research and practice may become marginalized. These concerns surfaced in a recent series of key informant interviews and focus groups organized by the National Collaborating Centre for Determinants of Health, where participants described health equity as “*becoming de-energized*” and at risk of being dismissed as a “*flavour of the month.*” (NCCDH, 2014, p. 9). Conversely, one might argue that achieving and promoting gains in health equity could very well be energizing, adding power to the movement that is building in order to effectively address the SDH.

Concerns about the potential marginalization of SDH due to a lack of political and financial commitment underscore the need for a greater focus on the processes by which SDH issues and policy options surface on the agendas of decision makers. Conceptual models of policy analysis, such as the MST, can provide helpful frameworks to describe, explain and predict policy processes.

Exworthy (2008) notes that the application of policy models to the SDH are important for two reasons. First, many SDH initiatives have been developed and transferred (often uncritically) between jurisdictions. However, the variability of context makes generalizability (both adoption and implementation) problematic. Second, the inherent nature of the SDH (i.e., multi-faceted phenomena with multiple inter-connected causal pathways) presents a unique set of challenges to

the policy making process. This necessitates the adoption of policy frameworks to specific jurisdictional contexts.

The paucity of relevant studies points to the need for a greater focus on the use of policy frameworks to analyze why SDH issues have/have not reached the policy making agenda. A systematic review conducted by Embrett and Randall (2014) confirmed the scarcity of literature on the application of policy analysis theory to the SDH. A search of 39 databases resulted in an extensive amount of peer reviewed SDH literature, generating over 6,200 articles. However, when the search parameters were combined with common policy analysis terms, only seven articles were found.

The proposed study addresses this gap through a multiple case study analysis of local (i.e., public health units) and provincial efforts to integrate SDH into the scope of public health practice in Ontario between 2000 and 2009, a timeframe characterized by the absence of explicit provincial directives and limited (at best) supports for SDH-focused public health initiatives.

Kingdon's MST, which focuses on how issues get onto the policy agenda and how proposals are translated into policy will be used as the theoretical framework for assessing the cases. The MST has been identified as especially pertinent to the SDH, given that struggles of SDH-focused initiatives to reach the policy agenda in spite of mounting evidence of their contribution to community and population-level health status (Exworthy, 2008).

To date, only a limited number of studies have applied the MST to assess the adoption of SDH-focused policies in the public health sector. However, these studies share two common shortcomings: a limited application of the theory's components, which, in turn, diminished its

explanatory power, and the absence of clear measures/constructs for operationalizing the theoretical concepts under study. The proposed study aimed to rectify these deficits through the development of an operational framework including key factors for each domain of the theory of relevance to the research questions (see Section 4.4). Moreover, the framework was tailored to the public health policy making context in Ontario, thereby meeting Exworthy's (2008) recommendation for maximizing the utility of policy analysis frameworks by adopting them to specific jurisdictional contexts.

The study has four inter-related purposes. Specifically, the study aims to:

1. Assess the utility of the three streams theory as a model for predicting the conditions under which local public health authorities were able to expand the scope of their mandates to address the SDH (i.e., acting on policy windows).
2. Identify key mechanisms within each of the three streams and the specific roles of policy entrepreneurs in creating policy windows enabling SDH-focused public health practice.
3. Make a practical contribution to improve the policy advocacy capacity of the public health system through a better understanding of the role of policy windows and how they may be influenced to enable the initiation of SDH-focused initiatives.
4. Make a practical contribution to the methodology for applying policy development theory to SDH-focused public health initiatives, an identified deficit in the public health literature (Embrett and Randall, 2014).

It is hoped that the insights gained from this study will inform both current and future efforts to expand the scope of SDH-focused public health practice. If advocates for an upstream, SDH-focused approach to addressing public health issues in Ontario can better understand and predict the opening of policy windows, then the odds of adopting and expanding SDH-focused initiatives may be increased.

3. Research Questions and Analytic Propositions

3.1 Research questions

The four primary, inter-related purposes of the study noted above (see Section 2) are embodied in the following research questions, which were used to guide the overall data collection, synthesis and analysis.

1. To what extent do the key constructs of the multiple streams theory define and predict the conditions under which local public health authorities were able to expand the scope of their mandates to address the SDH?
2. Are there additional factors (theoretical gaps) beyond the parameters of the multiple streams theory that need to be considered when defining and predicting the conditions favourable to SDH-focused public health practice?
3. Are there key mechanisms within each of the three streams (problem, politics and policy) that appear to be more/less salient in the creation of policy windows favouring SDH-focused public health practice?
4. What were the characteristics and roles of the policy entrepreneurs in advocating for SDH-focused public health practice that enabled or hindered the resulting policy changes?
5. What practical advice do the identified policy entrepreneurs (e.g., local health unit Medical Officers of Health) and other key actors have to offer about how to influence the opening of policy windows to foster SDH-focused public health initiatives?

3.2 Analytic propositions

The predictive value of the multiple streams theory in determining the likelihood of a policy's adoption in a specific context allows for the identification of potential analytic propositions. These refer to hypothetical findings regarding the theoretical concepts influencing the opening, or, in some cases, non-opening of policy windows enabling SDH-focused action by

‘early adopter’ public health units in the opening decade of the current century. The study assessed the following analytic propositions, which were developed through an initial review of the extant literature and primary documentation on the selected cases:

1. Action at some of the local health units was precipitated by focusing events, which resulted in changes in the problem stream.
2. Changes in the problem stream enabling local level action were also influenced by the increased collection and dissemination of information tied to key indicators – specifically, population-level data on the SDH. This, in turn, resulted from the predominance of the population health paradigm from the 1990s onward (see Section 5 for additional details).
3. Medical officers of health at the local health units played a critical role as policy entrepreneurs. The institutionalization of the entrepreneurial activities (i.e., within the local public health units) was a critical factor for the adoption of local level SDH initiatives, a finding confirmed by the aforementioned application of the multiple streams theory to healthy cities initiatives (DeLeeuw, 1999).
4. At the provincial level, the activities of the policy entrepreneurs reflected the persistence and protracted ‘softening up’ process necessary to achieve change (Kingdon, 2011). The importance of this process was evident in other studies applying multiple streams theory to the adoption of SDH initiatives (Gulfrandsson and Fossum, 2009; Strand and Fosse, 2011).
5. Within the political stream, the activities of the policy entrepreneurs may have reflected a protracted process of bargaining and trade-offs from ideal positions in order to gain wider support (Kingdon, 2011). Although the specific ‘ask’ of the policy entrepreneurs (i.e., SDH-specific program standards) was not granted, the province did incorporate space for SDH and equity focus planning in the 2008 Ontario Public Health Standards.

6. Key barriers in the political stream reflect tensions between the long-term nature of progress on the SDH vs. political demand to see short-term results. Barriers in the political stream also include the fact that SDH-focused solutions are not revenue neutral, which limited their political saleability in a climate of fiscal restraint (Lefebvre et al., 2006).
7. Barriers in the policy stream limited the reach and impact of the local level initiatives. These include: the blurring of responsibility and accountability for action due to the multi-faceted nature of the SDH, the lack of diversity among the PH workforce, and the lack of capacity for SDH-focused action among the PH workforce during the time in question (Lefebvre et al., 2006). Barriers in the policy stream also reflect the challenge of providing policy makers with a clear direction for SDH-focused solutions (Exworthy, 2008).
8. It is not certain whether a full coupling of the three streams, a pre-requisite necessary for effective, sustained policy change (Kingdon, 2011), took place in each of the identified cases. The implementation of SDH-focused initiatives at some of the local public health units may have resulted from a “partial coupling”, a convergence of two streams. In these instances, the impact and sustainability of the resulting actions were limited by barriers in the third stream.
9. At the provincial level, a full coupling of the streams may not have been achieved due to barriers in any one of the three streams. These include: accountability challenges arising from the multi-sectoral nature of SDH work (policy stream), concerns about the revenue implications of solutions (politics stream), the long term nature of SDH outcomes (politics stream), a lack of public perception/understanding of links between health status and the SDH (Canadian Institute for Health Information, 2005), and timing relative to other issues on the agenda of public health decision makers, especially the need to strengthen provincial capacity for communicable disease control in the wake of SARS (problem stream).

4. Methodology

4.1 Rationale for case study methodology

Case studies are in-depth investigations of a phenomenon in its real life context (George and Bennett, 2004; Yin, 2009). To understand complex phenomena, such as the adoption of SDH-focused public health practice, it is often useful to go beyond a single case by focusing on the operationalization of the phenomena at several locations. A **multi-case design**, which closely examines several cases linked together by common elements (Stake, 2006), was employed for the present study.

Multi-case designs have been identified as optimal for the study of the factors promoting and inhibiting policy development (Herriot and Firestone, 1983; Walt et al., 2008). Specifically, comparisons between similar (and divergent) jurisdictional contexts can help to disentangle generalizable from context-specific effects in the policy adoption and implementation process (Walt et al., 2008).

The basic typology of case studies, which encompasses variations of categories first developed by Lijphart (1971) and Eckstein (1975), consists of idiographic (i.e., non-generalizing focus on a particular case), hypothesis generating and hypothesis testing cases, which can confirm or inform theory. These are ideal types, and in practice case study research often combines several of these aims (Levy, 2008). The present study combines elements of theory-guided hypothesis testing and hypothesis generating cases.

Theory-guided, hypothesis-testing case studies are idiographic in that they aim to explain or interpret a single historical episode (e.g., an attempt to adopt SDH-focused practice at

a single public health unit). Unlike inductive case studies, however, they are explicitly structured by a well-articulated conceptual framework (in this case, Kingdon's multiple streams theory) that focuses attention on some theoretically specified aspects of reality. **Hypothesis generating case studies**, by contrast, aim to generalize beyond the data by examining multiple cases for the purposes of exploring or developing theoretical propositions in specific contexts (i.e., how multiple streams theory can guide future advocacy efforts for SDH-focused public health practice by elucidating factors related to the opening of "policy windows" and effective practices by "policy entrepreneurs").

Case studies can be especially useful in explaining cases that violate theoretical predictions and to refine or replace existing hypotheses, including the parameters of a theory's scope (Levy, 2008). However, such theory-driven research is not without its limitations. Given the structured, 'a priori' nature of theory-based research, the researcher cannot identify the unintended artefacts of empirical data; rather, reported experiences are filtered through the circumscribed view offered by a theoretical lens (Coryn et al., 2010). Moreover, theory-driven researchers have been accused of focusing solely on the testing of theory, thereby pursuing a purely deductive approach that ignores social problems at the expense of theoretical development (Stufflebeam and Shinkfield, 2007). Although this is not necessarily problematic, there are moral and ethical implications if this tendency surfaces in research that ultimately aims to extend empirical knowledge and inform policy and practice (Meyer and Ward, 2014).

To guard against the potential limitations of theory-driven research, the present study incorporates elements of a methodology for the integration of theory in qualitative research developed by Meyer and Ward (2014). This entailed the development of a conceptual framework

for operationalizing the theory that includes key concepts as well as relevant indicators for these concepts. In addition, the study aimed to uncover both theoretical and empirical gaps, a step that is often absent from theory-driven research. The implementation of these steps - which help to ensure a pluralistic approach for theory verification and generation (Meyer and Ward, 2014) – are described in greater detail in Sections 4.4 and 4.5.

4.2 Rationale for selection of cases

A central question to ask of any case study is “what is it a case of?” (George and Bennett, 2004; Levy, 2008). As was noted previously, the study will focus on the application of the multiple streams theory to six cases: five local cases and one province-wide case. The **local cases** comprise five public health units that integrated SDH into their scope of activities in the opening decade of the current century (i.e., 2000 to 2009). Specifically, these health units are:

- Peterborough City-County Health Unit (PCCHU),
- Leeds, Grenville and Lanark District Health Unit (LGLDHU),
- Region of Waterloo Public Health (RoWPH),
- Huron County Health Unit (HCHU), and
- Sudbury and District Health Unit (SDHU).

From 2005-2007, representatives from all of these health units, in collaboration with several other health units and provincial organizations representing public health interests, made a concerted attempt to influence public health policy at the provincial level (Lefebvre et al., 2006). This effort, which focused on the development of proposed SDH program standards and advocacy for their inclusion in the mandated scope of practice document for public health units (which was then undergoing revision), constitutes the **province-wide case study**.

Several considerations guided the selection of local health units for inclusion in the study. First, contemporary documentation published during the time frame of the study acknowledged the innovative contribution to SDH-focused practice made by four of the five local cases (Raphael, 2003; Gardner, Arya and McAlister, 2005; Lefebvre et al, 2006). Second, all of the selected cases were signatories to the proposed SDH-focused provincial standards (i.e., the province-wide case study) and advocated for their adoption (Lefebvre et al., 2006). Third, all of the local cases were well documented through reports, meeting minutes, and other primary sources, thereby enabling the triangulation of data and a more robust analysis than would have been possible through key informant interviews alone. Last, the selected cases reflect the geographic diversity of Ontario, which, in turn, allowed for a more robust exploration of contextual factors affecting the adoption and implementation of SDH-focused public health actions.

Although some of the **local-level SDH initiatives** carried out by these health units may not seem especially innovative by contemporary standards, they provide an opportunity to explore how policy entrepreneurs (i.e., Medical Officers of Health and senior management) in these organizations were able to influence and act upon the opening of policy windows in a socio-political environment characterized by a dearth of directives, resources and supports for SDH-focused public health practice at both the local and provincial levels. The **province-wide case study** provides an opportunity to examine if/how lessons learned from community-level experiences informed the policy entrepreneurs' efforts to influence and act upon the opening of policy windows at the provincial or 'system' level. Moreover, the province-wide case study also allows for the examination of system level factors within each of the three streams that enabled or hindered consideration of SDH-focused public health policies at the provincial level.

4.3 Data collection

4.31 *Review and Analysis of Relevant Documentation*

This component of the study encompassed a review of both primary and secondary materials related to the cases. Primary sources refer to original source material documenting a key event or milestone, including all evidence contemporary to the event (e.g., meeting minutes, reports or newspaper articles). Secondary sources refer to everything that has been written about the event since its occurrence, including interpretations by historians (Kragh, 1987). In practice, however, this distinction can sometimes become blurred when one considers questions such as how contemporaneous an account of an event must be in order to be considered “primary”? (Thies, 2002).

Primary sources reviewed as part of the study included:

- minutes of the Board of Health meetings at the defined health units during the time frame defined by the study (2000-2009);
- documents describing the initiation and operation of equity-focused initiatives in the selected health units;
- annual reports of the selected health units;
- documents describing the proposed provincial case; the 2005-2006 effort by local-level public health leaders to establish a mandatory provincial SDH standard (e.g., Lefebvre et al. 2006);
- agendas and proceedings of key meetings and conferences that advanced SDH-focused work in the selected health units (cited by key informants or in primary documentation)
- media sources (e.g., local newspaper articles) describing SDH-focused public health initiatives at the selected health units;
- media sources describing community conditions/antecedent events that may have affected the development of these initiatives;
- evaluation reports on the implementation/impact/outcomes of the SDH-focused initiatives that occurred within the selected cases.

In addition, primary data was accessed to construct socio-demographic profiles of the catchment areas served by the selected local health units during the defined time frame (2000-2009). These sources, including as demographic summaries from 2001 and 2006 census data as well as SDH-related statistics compiled by the health units and local organizations (e.g., social planning councils), helped to identify how social and economic circumstances in these communities may have affected each of the three streams and the subsequent opening of policy windows.

4.32 Key Informant Interviews

Interviews were conducted with twenty respondents with direct knowledge of and/or lived experience with the local and provincial cases. Specifically the respondent group included:

- Medical Officers of Health who led the selected health units during the time period in question or played a key role in the advocating for SDH standards at the provincial level (N=6);
- senior staff at the health units (e.g., Directors, Managers), who were instrumental in the development of the local SDH-focused initiatives (N=8);
- local-level ‘champions’ (e.g., board of health members, elected municipal/regional politicians or CEOs of community agencies) that actively supported the development of the local level SDH-focused public health initiatives (N=6).

Table 1 notes of all the respondents interviewed for this study, as well as their roles (at time of the case). Respondents were selected using a purposive approach to sampling. Purposive sampling, which is sometimes referred to as purposeful sampling (e.g., Cresswell, 2013), refers to the strategic identification of individuals who: a) best exhibit (or are best prepared to speak to) the characteristics or phenomena of interest, and b) are most accessible and conducive to gaining understanding of the topic(s) of interest (Maxwell, 2012). Initial contacts were made with the

health unit MOHs, who were asked to identify key senior staff and community champions who were instrumental in initiating the local and/or provincial-level SDH initiatives.

Table 1: List of Key Informant Interview Respondents

Case(s)	Respondent Category	Role at Time of Case
PCCHU Ontario	MOH	PCCHU MOH (2007-) Advocate for adoption of province-wide SDH standards (Ontario case)
PCCHU Ontario	Health unit staff	Director, Health Promotion
PCCHU	Health unit staff	Public Health Nutritionist
PCCHU Ontario	Health unit staff	Health Promoter, Poverty and Health (2007-)
PCCHU	Community champion	Member, Peterborough Poverty Reduction Network and Mayor's Action Committee on poverty (2007-)
PCCHU	Community champion	Community Development and Training Supervisor, YWCA of Peterborough, Victoria and Haliburton
LGLDHU Ontario	MOH	LGLDHU MOH (until 2005) Founder and Chair of LGL Health Forum (2000-2003) Advocate for adoption of province-wide SDH standards (Ontario case)
LGLDHU	Community Champion	Executive Director, Family and Children's Services of Brockville Chair, SDH Committee, LGL Health Forum (2000-2003)
LGLDHU	Community Champion	CEO, Brockville General Hospital Chair, Access Committee, LGL Health Forum (2000-2003)
RoWPH Ontario	MOH	RoWPH MOH (2001-)
RoWPH Ontario	Health unit staff	Director, Health Determinants Planning and Evaluation Division
RoWPH Ontario	Health unit staff	Manager, Population Health Planning and Evaluation, Health Determinants Planning and Evaluation Division
HCHU Ontario	MOH	HCHU MOH (until 2008)
HCHU Ontario	Health unit staff	Director and CEO, HCHU (until 2008)
HCHU	Community Champion	Mayor of Goderich Chair, HCHU Board of Health (2003-2007) Huron County Warden (2003-2007)
SDHU Ontario	MOH	SDHU MOH (2000-) Advocate for adoption of province-wide SDH standards (Ontario case)
SDHU Ontario	Health unit staff	Director, Health Promotion Division
SDHU Ontario	Health unit staff	Manager, Health Equity (2006-)
SDHU	Community Champion	ED, Social Planning Council of Sudbury Sudbury City Councillor (2003-2010) Chair, SDHU Board of Health (2004-2010)
Ontario	MOH	MOH, Northwestern Health Unit (until 2007) Advocate for adoption of province-wide SDH standards (Ontario case)

Semi-structured interviews of approximately 45-60 minutes duration were conducted for all respondents. The semi-structured interview format was selected because of its flexibility in allowing the researcher to combine pre-determined, standardized questions, which enable generalization across cases (health units), with the freedom to digress and insert probes when greater elucidation about a particular issue or theoretical construct is warranted (Berg, 1989). The use of semi-structured interviews is especially useful, since the range of SDH-focused activities during this time frame examined by the proposed study were arguably more diverse and case-specific than the more standardized, mandated approach currently in place at Ontario health units. Three separate interview protocols were developed for data collection: one for MOHs, one for senior PHU staff and one for community allies. These are provided in Appendices A-C.

With the consent of the respondents, the interviews were digitally recorded and full transcripts of each recording were prepared for analysis. Each respondent received a transcript of their interview to review for accuracy and completeness.

4.33 *Ethical Considerations*

The study received ethics clearance from the University of Waterloo Office Of Research Ethics in June 2015. All respondents received a written request for participation describing the purpose of the study, the key research questions, data collection procedures (e.g., digital recording) and how the data would be used (i.e., as information for the completion of doctoral thesis and potential related publications). In addition, all respondents had the opportunity to clarify questions and issues with the investigator prior to providing written consent.

Efforts were made to protect the anonymity of respondents throughout the study. Direct quotations were only used with the consent of the respondents. Although respondents were not named directly in the study findings, their roles (e.g., MOH, BOH Chair) were indicated to illustrate the nature of their contribution to the cases under study. Consent for attributable (i.e., role-defined) quotes was provided to the investigator at the time when full interview transcripts were shared with respondents.

4.4 Framework guiding data collection and analysis

The development of all data collection instruments, including criteria for analyzing the selected documents and the key informant interview guides, was informed by the creation of sensitizing concepts. Originally developed by Blumer (1954), sensitizing concepts are a set of proposed concepts or interpretive devices that serve as a starting point for qualitative inquiry. Specifically, sensitizing concepts provide the researcher with a sense of how observed or documented instances of a phenomenon might fit within broader theoretical constructs or categories (Bowen, 2006). This aids in the identification of background ideas that inform and refine the overall research problem (Charmaz, 2003).

The use of sensitizing concepts also helps to address the aforementioned limitations of theory-driven research identified by Meyer and Ward (2014). In addition to forming the basis of a conceptual framework to operationalize the totality of a theory, sensitizing concepts can also be used to explore potential theoretical gaps. Table 2 presents the proposed sensitizing concepts that served as operational indicators of the proposed constructs specified by Kingdon's MST. They have been customized for the specific context/setting under study (i.e., SDH-focused public

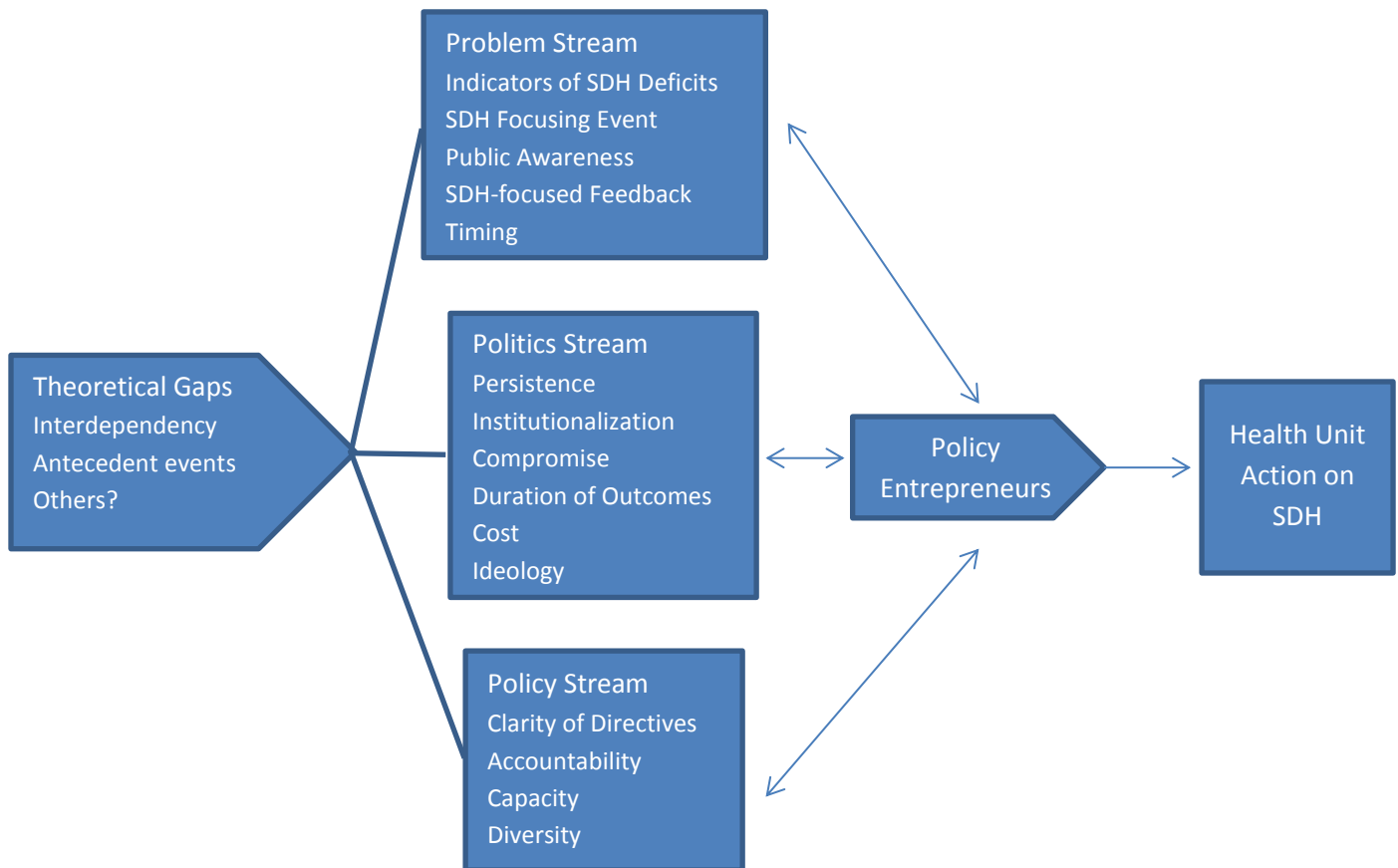
health practice in Ontario) and have been expanded beyond the limits of the theory to include potential gaps that have been identified from the literature (see sections 1.2-1.3).

Table 2: Sensitizing Concepts for Development of Data Collection Instruments

Concept/Relevance to Theory	Definition
Indicators of SDH deficits (Problem stream)	Adoption of population health paradigm led to increased collection/utilization of population level SDH data
SDH-specific focusing event (Problem stream)	Key events in community resulting in increased attention to inequitable access to the SDH (Gardner, Arya and McAlister, 2005, CPHA, 2014).
Public awareness (Problem stream)	Lack of public awareness/understanding of SDH. Potential barrier to provincial-level action (CIHI, 2005)
SDH-focused feedback (Problem stream)	Information about limitations of existing (within defined timeframe) limitations of PH programs for SDH likely to arise from informal means
Timing (Problem stream)	Ability to secure SDH-focused public health practice on provincial agenda hampered by competing demands (i.e., efforts to strengthen communicable disease control in wake of SARS).
Persistence (Politics stream)	Length/intensity of engagement of chief policy entrepreneurs (MOHs) in advocating for SDH-focused public health practice (Gulfbrandsson and Fossum, 2009; Strand and Fosse, 2011)
Institutionalization (Politics stream)	Ability of entrepreneurs to act ‘within’ the system. Identified as a critical factor for adoption of SDH-focused public health practice (DeLeeuw, 1999)
Compromise (Politics stream)	Evidence of bargaining and acceptance of ‘trade-offs’ by policy entrepreneurs to gain wider support for SDH-focused action
Duration of outcomes (Politics stream)	Long term effects of SDH work vs. political expectations to see short term results. Potential barrier to action (Lefebvre et al., 2006)
Cost (Politics stream)	Concerns about revenue implications of SDH-focused public health work. Potential barrier to action (Lefebvre et al., 2006)
Ideology (Politics stream)	Extent to which political ideology of decision makers enabled/hindered adoption of SDH-focused public health practice
Clarity of directives (Policy stream)	SDH-focused ‘solutions’ often fail to provide clear direction for policy makers (Exworthy, 2008). Potential barrier to action
Accountability (Policy stream)	Multi-sectoral nature of SDH policy poses accountability challenges (Lefebvre et al, 2006; Exworthy, 2008). Potential barrier to action
Capacity (Policy stream)	Knowledge/ability of public health workforce (within defined timeline) to effectively plan, implement and assess SDH-focused initiatives— Potential barrier to action (Lefebvre et al., 2006)
Diversity (Policy stream)	Extent to which composition of public health workforce reflects demographics of marginalized communities. Potential barrier to action (Lefebvre et al., 2006)
Interdependency (Theoretical gap)	Extent to which the three ‘streams’ of factors affecting SDH-focused public health practice demonstrated ‘interdependence’ (Mucciaroni, 1992), as opposed to ‘independence’ (Kingdon, 2011)
Antecedent events (Theoretical gap)	Influence of previous events/policy decisions on adoption of SDH-focused public health initiatives (Sabatier, 1988; Weir, 1992; Hall, 1993)
Additional theoretical gaps (TBD)	Identification of other critical factors and patterns of action not covered by multiple streams theory through data collection and analysis.

A framework linking the above concepts to the key components of the MST and the research questions of interest (see Section 3) is depicted in Figure 2. In keeping with the proposed approach to data collection, this Figure also depicts the potential role of theoretical gaps in the elucidation of key factors affecting the implementation of SDH-focused initiatives by early adopter health units. Unlike other depictions of the MST (see Figure 1), which portray a linear, unidirectional relationship between the three streams and the actions of the policy entrepreneurs, the arrows connecting these aspects of the model in Figure 2 denote a symbiotic relationship, whereby the actions of the policy entrepreneurs can both influence, and be influenced by, each of the streams.

Figure 2: Application of Multiple Streams Theory to SDH-Focused Public Health Action: A Proposed Model



4.5 Data analysis

Transcripts of all key informant interviews were written using Word software and uploaded onto NVivo 10 for analysis. The analytic propositions and sensitizing concepts (Sections 3.2 and 4.4 respectively) developed for this study provided a structured framework for an explanatory analysis of the interview data and associated case study documents based on the tenets of multiple streams theory. To that end, coding nodes were developed for each of the MST-related sensitizing concepts depicted in Table 1. However, as was noted earlier, the use of a prescribed theoretical framework for analysis can lead researchers to disregard data relevant to the research questions (Meyer and Ward, 2014). This risk was, in part, mitigated through the inclusion of suspected and potential ‘theoretical gaps’ in the sensitizing concepts. Nodes for key variables that appeared to fall outside the parameters of MST were subsequently created through an open coding process.

The analysis of the historical (documentation) and key informant interview data was also guided by the creation of memos. NVivo enables the juxtaposition of data with memos that illuminate different aspects of the study (Bazeley, 2007). These included: **interview or participant memos** summarizing the key points of an interview and related impressions; **node memos** describing why a particular theme is significant, and **query results memos**, which are written in response to outstanding issues and questions warranting further analysis.

The results of this analysis are presented in Sections VII and VIII. However, to fully understand the factors that gave rise to early SDH-focused initiatives by Ontario PHUs, it is helpful to understand the antecedent factors that set the context for this work.

4.6 Limitations of methodology

One of the study limitations concerns the absence of several key respondents. It was originally hoped that provincial officials and appointees of the Technical Review Committee (TRC) established to develop what would become the Ontario Public Health Standards would consent to be interviewed in order to gain insights into factors affecting provincial decisions around the incorporation of the SDH into the legal mandate of Ontario's PHUs. However, these individuals were not able to participate due to binding agreements prohibiting the disclosure of confidential information. In addition, two former MOHs involved with the local cases, one of whom has subsequently retired and the other who has since transitioned into private practice, did not respond to requests for interviews.

Another limitation concerns the potential generalizability of the study findings beyond Ontario to other provinces and jurisdictions. This is due to Ontario's unique position as the only province in Canada where public health services are administered through joint municipal-provincial system of governance (Deber et al., 2006). However, this limitation is somewhat mitigated by the inclusion of both local and provincial cases, which allowed for the assessment of political and policy considerations both within and between these two levels of government.

Lastly, as a multiple case comparison of historical phenomena, the study is vulnerable to the potential shortcomings of case study research and oral history. These include recall bias (including the tendency of respondents to create a 'useable past' by altering the chronology of events to create a more logical narrative), selecting cases with limited generalizability, a lack of rigour, and theoretical bias in interpretation (Green and Troup, 1999; Crowe et al., 2011). These limitations were minimized through a number of safeguards, including: the development of analytic propositions and sensitizing concepts grounded in the theoretical and empirical

literature; the triangulation of data that enabled the cross checking of interview transcripts with primary documentation to establish an accurate sequence of events; member checking of transcripts; and a data analysis that combined theory-based coding with a more open coding process to allow for the emergence of potential explanatory variables beyond the parameters of MST.

5. Setting the Context Part I: A Historical Overview of SDH-Focused Public Health Initiatives in Ontario (1910-2000)

Up until the end of the nineteenth century, public health in Ontario and the rest of Canada focused mainly on the building and maintenance of public general hospitals and the enactment of sanitary regulations to prevent communicable diseases (Badgley, 1978). Although Ontario passed its first *Public Health Act* in 1873, a key milestone enabling an expanded scope of public health practice appears to have occurred in 1884, when an amendment to the *Public Health Act* legally defined the role of medical officers of health and their relationship with local boards of health (MacDougall, 1990); within two years of its passage over 400 boards of health were in operation (aLPHa, 2010). The influence of local medical officers of health was further strengthened in 1909, when amending provincial legislation allocated funding for preventive work on the same basis as taxation for school boards (MacDougall, 1990).

These legislative reforms coincided with Canada's transformation from an agrarian to industrial economy, with over 40 percent of Canadians dwelling in urban areas by 1900 (Ostry, 1995). But the employment opportunities afforded by manufacturing and resource processing jobs in urban centres came at the cost of health and social problems, including poor housing, overcrowding, pollution, poverty, outbreaks of communicable diseases, and premature morbidity and mortality (Valverde, 1991; Ostry, 2006). Urbanization had an especially deleterious impact on the health of children: by 1905, the mortality rate of urban children in Canada was 35% higher than their rural counterparts (Ursel, 1992).

The earliest documented example of an Ontario health department using its legislative authority to address the ‘upstream’ causes of ill health commenced in 1910 with the appointment of Dr. Charles Hastings as Toronto’s fourth medical officer of health. Hasting’s shrewd political acumen enabled him to successfully engage with civic politicians, while the 1909 provincial funding gave him a resource base to expand public health’s reach into areas that his predecessors were not able to address. As a result, he is rightfully remembered for his success in bringing about sorely needed reforms to reduce Toronto’s risk of communicable disease. These include the pasteurization of the city’s milk supply, the chlorination of the city’s water supply, and the mandatory inspection of all slaughterhouses, grocery stores and restaurants (MacDougall, 1990; Hancock, 1997).

Less attention has been paid to Dr. Hasting’s role in expanding the mandate of Toronto’s health department to encompass the more ‘upstream’ causes of health currently defined as the SDH. Guided by the principles of progressive social reform (Hurl, 1984), Hastings blamed poverty for much of the preventable illness affecting Toronto, and became a pioneer advocate for public housing in the wake of a 1911 report of the public health department exposing conditions in Toronto’s slum areas. Numerous studies conducted during Hastings tenure focused on the severe malnourishment of children in Toronto’s low-income neighbourhoods (MacDougall, 1990).

While Hastings emphasized the need for individuals to take responsibility for their health, he also spoke to the obligation of society as a whole to care for the health of its citizens. Although the terminology has changed since Hasting’s time, the following excerpt from a 1918 address he gave to the American Public Health Association reveals a strong commitment for

access to the social determinants of health as a basic human right as well as a call to action against health inequities that could be considered unavoidable and unjust:

“Every nation that permits people to remain under the fetters of preventable disease, and permits social conditions to exist that make it impossible for them to be properly fed, clothed and housed, so as to maintain a high degree of resistance and physical fitness, and that endorses a wage that does not afford sufficient revenue for the home, a revenue that will make possible the development of a sound mind and body, is trampling a primary principle of democracy under its feet.” (Hastings, 1918, cited in MacDougall, 1990, p. 27).

During Hasting’s term as Medical Officer of Health, Toronto addressed the health impacts of poverty through a combination of programs and administrative changes aimed at achieving a more coordinated response to the SDH. Toronto’s health department tried to counterbalance childhood malnutrition through the distribution of free milk. Well baby clinics were established, and nursing staff were sent into the community to dialogue with residents about a wide range of issues pertaining to disease prevention, child welfare and social service. In 1921, during a time of high post-war unemployment, the health department established a Social Welfare Division, which connected individuals and families in need to social agencies (MacDougall, 1990). Hastings also played an instrumental role in the creation of the Toronto Housing Company, a co-partnership initiative designed to promote slum clearance by providing affordable housing to working class families (Hurl, 1984).

The reforms initiated by Dr. Hastings had a positive impact on the health and well-being of Torontonians. A 1915 *Maclean’s* magazine article, “Saving Lives on the Wholesale Plan: How Toronto has been made the Healthiest of Large Cities”, compared the health status of Toronto with similar large cities (i.e., population over 300,000) in Great Britain and the United States. The article found that Toronto had the lowest mortality rate, followed by Milwaukee, New York, Chicago and the large British cities (cited in Hancock, 1997, p. 14).

Many of the measures introduced under Dr. Hasting's administration, such as the mandatory pasteurization of milk, were subsequently adopted province-wide and remain in place to this day. In addition, Hasting's initiation of community-level initiatives addressing the SDH was cited as a key stream of influence guiding the emergence of the Healthy Cities/Communities movement in the 1980s (Hancock, 1997).

Yet other reforms proved to be relatively short-lived. For example, the Social Welfare Division of Toronto's health department was disbanded in 1931, two years after Dr. Hasting's stepped down as the city's medical officer of health (MacDougall, 1990). Its replacement with a separate Department of Public Welfare marked a demarcation between the role of public health and the social welfare policies impacting on population health status.

MacDougall (1990) notes that the impact of the Social Welfare Division was limited by its adoption of prevailing American social work techniques that encouraged professional detachment and stressed the importance of individual responsibility over participation in community programs to address poverty and other systemic health problems. Other historians have questioned whether the department's wide-ranging activities targeting the poor were entirely benign. For example, entering the homes of low-income women on the assumption that they lacked the knowledge to prepare healthy meals made the department unpopular in many neighbourhoods and revealed a regimen of moral regulation underlying reformist impulses (Hurl, 1984; Valverde, 1991).

Local public health authorities in Ontario appear to have been relatively silent on issues related to health equity and the SDH from the 1930s to the early 1980s. This may be attributable

to several factors. First, the success of labour unions and social change movements in advocating for the establishment of universal medicare, unemployment insurance, and other components of the ‘social safety net’ greatly eradicated the prevalence of unhealthy living conditions witnessed by public health advocates earlier in the century. Second, Canada, like other western countries, enjoyed consistently robust economic growth during the thirty years following the end of the second-world war, which greatly reduced both the extent of poverty and its political salience as a priority for action (O’Neill, 2012). Last, and perhaps most important, the locus of public health practice was gradually shifting from infectious diseases to chronic, non-communicable pathologies such as heart disease, cancer and stroke. These conditions, which were beginning to supplant communicable diseases as the leading cause of death in western countries by the middle of the twentieth century, were initially regarded as consequences of “lifestyle” choices (e.g., smoking) rather than adverse social and economic circumstances.

By the 1970s concern over rising health care costs provided an additional impetus for health promotion programs encouraging the adoption of healthier lifestyles (Green, 1974; Crawford, 1977). The prevailing ‘risk factor reduction’ approach to health promotion received the explicit endorsement of the Canadian government with the 1974 publication of *A New Perspective on the Health of Canadians* (Lalonde, 1974). The Lalonde report - as it was more commonly known (in recognition of the Minister of Health who oversaw its production) - was regarded as a milestone document that resulted in the international recognition of health promotion as a viable discipline within the broader field of public health (Pinder, 1994).

The Lalonde report was notable for its introduction of the **health field concept**, which defined health outcomes as a product of four elements: human biology, lifestyle, environment

and health care organization. In spite of this broad framework, personal responsibility for all aspects of health and illness is emphasized throughout the report. Unhealthy practices are described as “self-imposed risks” (p. 18), while the section of the report dealing with health status (p. 26) contends that “*individual blame must be accepted by many for the deleterious effect of health of their effective lifestyles*”. Although the influence of the environment, defined by the report as “*all those matters related to health which are external to the human body over which the individual has little or no control*” (p. 32), is acknowledged, the report recommends that “*the deterministic view be put aside in favour of the power of free will, hobbled as this power may be at times by environment and addiction*” (p. 36).

By the beginning of the 1980s, the reductionist approach to health promotion typified by the Lalonde report was falling into disrepute (Labonte and Penfold, 1981). In the United Kingdom, ground-breaking social epidemiologic studies such as the Whitehall I study (Marmot et al., 1978) and the Black report (Black et al., 1980) revealed significant inequities in the health status of lower socio-economic groups that could not be accounted for by personal choices alone. Other studies emanating from the field of social epidemiology underscored the importance of supportive networks on the health of individuals (Berkman and Syme, 1979).

In Ontario, a number of public health leaders disillusioned by the prevailing approach to health promotion embraced the participatory, action-oriented approaches to community development and policy advocacy utilized by the social change movements of the 1960s. The concepts and approaches defining this phase originated in a planning document, *Public Health in the 1980s*, prepared for the Toronto Board of Health in 1978. The report took a broad view of health and the range of actions necessary to support it. These included the establishment of

community health boards with lay representatives and the creation of issue-based capacity for political advocacy within the health department (Pederson and Signal, 1994). Action on the latter priority occurred in 1979 with the department's creation of a Health Advocacy Unit. Over the course of its existence, the Unit initiated public debates on a range of 'upstream' SDH issues, including air quality, poverty and health in the workplaces (Labonte, 1994). The Unit's willingness to openly challenge both local and provincial authorities for their inaction on key health problems was cited as a critical factor contributing to its dissolution in 1982, although formal staff of the Unit continued to serve as advocates for reform, both within the city of Toronto and through their respective professional associations, particularly the Ontario and Canadian Public Health Associations (Pederson and Signal, 1994).

More sustainable progress emanated from two landmark conferences organized by the Toronto health department in the early 1980s: the *Shifting Medical Paradigms Conference* held in 1980 and the *Beyond Health Care Conference* held in 1984 (Hancock and Duhl, 1986). The proceedings of these events articulated a vision of public health practice focused on enabling communities to take action on self-identified health priorities such as poverty, environmental contaminants, inadequate housing or lack of access to nutritious foods. Many of the public health issues raised at these events are easily recognizable on contemporary SDH lists (e.g., Mikkonen and Raphael, 2010). The *Beyond Health Care Conference* was also noteworthy for introducing the term "healthy public policy" to the public health lexicon. Building healthy public policy would subsequently be included as one of the key action areas of the *Ottawa Charter* (WHO, 1986), which continues to be regarded as the seminal document defining the parameters of health promotion practice.

Perhaps the most enduring legacy of this second phase of public health action on the SDH in Ontario was the creation of the Healthy Cities/Healthy Communities movement. The idea of a healthy city project, which provided funding, infrastructure and support for geographically-defined communities to take action on shared health concerns, was initially introduced at a one-day workshop following the *Beyond Health Care Conference*. High levels of commitment from key stakeholders led to the launch of the Toronto Healthy City Office in 1989 (Pederson and Signal, 1994). Healthy communities projects were subsequently created throughout Ontario, initially with support from the Canadian Healthy Communities project (a three year demonstration project funded by Health and Welfare Canada), and more recently (since 1992) from the Ontario Healthy Communities Coalition (Manson Singer, 1994; Simard et al., 2012). Since their inception, the healthy cities/healthy communities movement has supported community-based efforts focusing on, but not limited to, equity-related issues including poverty reduction, community economic development and food security (Raphael, 2012; Simard et al., 2012).

The ideas put forward by the advocates of the second phase of action on SDH in Ontario had a significant impact on policy making at the provincial level. Three reports commissioned by successive provincial governments on the future of health care in Ontario, while distinct and responding to different mandates, articulated a common vision of what was needed to improve the health and quality of life of all Ontarians (Pederson and Signall, 1994). This included a greater focus on equity, a shift in emphasis from ‘sickness care’ to health promotion, and greater opportunities for individuals to engage in decisions affecting their health (Corlett, 1988). During this time, the provincial government also established the Office of Health Promotion, which later became the Health Promotion Branch, as well as the Premier’s Council on Health Strategy (later

re-named the Premier's Council on Health, Well-being and Social Justice), a progressive social policy think-tank that advanced health promotion concepts into the mainstream of government policy making. In 1993-94, the Council funded the first province-wide study of inequities in the health status of Ontarians. Using data from the Ontario Health Survey (1990), the study results upheld the established linear gradient between income level and self-rated health status: only 43 percent of 'very poor' Ontarians (with an income of \$11,199 or less) reported very good or excellent health compared with 51 percent among the 'poor' (\$12-19.9k), 58 percent among the lower middle-class (\$20-39,9k), 62 percent among upper income earners (\$40-79.9k), and 69 percent among wealthy Ontarians earning \$80,000 or more (Warren, 1994).

In their summation of the progress achieved during this period, Pederson and Signal (1994, p. 244) identified a "broad view of health and its determinants as the major accomplishment of the health promotion movement in Ontario to date." By the mid -1990s, however, this "broad view of health and its achievements" faced two key challenges. First, a prolonged economic recession in Ontario limited the amount of resources available for equity-focused health promotion work (O'Neill, Peterson and Rootman, 2000). Second, population health, which emphasized the importance of addressing the SDH at the population level within an epidemiologically-oriented framework (Evans, Barer and Marmot, 1994), gained influence and support as an alternate paradigm.

Population health has been criticized for offering little in the way of tackling health inequities (other than research), favouring epidemiology over other forms of knowledge, and neglecting the role of healthy public policy and community development in shaping equitable access to the SDH (Labonte, 1995; Robertson, 1998). Conversely, it could be argued that, over

the long term, population health had a degree of positive influence over action on health inequities insofar as it provided a clearer articulation of the key determinants affecting health status and emphasized the greater potential impact of population-level interventions as opposed to the more limited reach of community-specific efforts.

The climate of fiscal restraint constraining the second phase of action on the SDH in Ontario reached its apex in 1995 with the election of a provincial government that campaigned on *The Common-Sense Revolution*, a neo-liberal platform combining steep tax cuts with corresponding decreases in government spending, including a 20% cut in ‘non-priority’ spending (exempting health care, law enforcement and in-class education) and a 21.6% cut in payments to social assistance recipients (Progressive Conservative Party of Ontario, 1994; Stapleton, 2015). In September 1995, the Premier’s Council was disbanded along with the healthy community grants program, an initiative launched in 1989 by the provincial Health Promotion Branch and expanded in 1994 to provide seed funding for community-based projects addressing the SDH (Hyndman, 2007).

At the municipal level, the healthy cities movement was enduring heavy criticism in its birthplace. The Toronto Healthy City office narrowly escaped closure in the fall of 1993 after city council inadvertently passed a motion to that effect. The ensuing debate among city councillors revealed deep concerns about the project’s impact and value for money (Rachlis and Kushner, 1994). The office was subsequently re-structured and downsized before shutting down in 2001 (Raphael, 2012).

The setbacks in SDH-focused public health practice during the 1990s were offset by one small, albeit noteworthy, development: the addition of an equal access standard to the 1997

Mandatory Health Programs and Service Guidelines (Ontario Ministry of Health, 1997).

Provincial guidelines specifying the scope of public health programs were first released in 1984 as part of an effort to modernize public health service delivery that began with the replacement of the *Public Health Act* with the *Health Protection and Promotion Act* (HPPA) in 1983 (Pederson and Signal, 1994). Both the 1984 guidelines and a revised version released in 1989 were silent on issues related to health equity and the SDH. The equal access standard of the 1997 guidelines required Boards of Health to “*provide mandatory public health programs and services, whenever practical and appropriate, which are accessible to people in special groups for whom barriers exist*” (1997, p. 6). Barriers were defined as including, but not limited to “literacy level, language, culture, geography, social factors, education, economic circumstances and mental and physical ability” (ibid). The equal access standard, while relatively modest in scope and limited to consideration of health equity in terms of service access, was still an important milestone as it required all Ontario health units to explicitly address equity issues in the planning and delivery of public health programs and services. Over the ensuing decade, several health units would utilize this standard as a basis for launching SDH-specific initiatives.

6. Setting the Context Part II: Ontario in 2000

On Saturday January 1, 2000, over 11 million Ontarians awoke to a new millennium. The *Toronto Star*, which published a special edition to mark the occasion, described a prevailing mood of celebratory jubilation combined with a sense of relief that the anticipated chaos resulting from the ‘Y2K’ computer programming issue had not come to pass (van Rijn and Chung, 2000). “*Y(ikes) 2K quickly becomes Y(awn) 2k*” was one of the feature headlines (Taylor, 2000).

Ontario entered the new millennium during a period of robust economic growth. An economic and revenue outlook paper prepared by the Ontario Ministry of Finance in advance of the May 2000 provincial budget portrays a province enjoying the benefits of booming job creation, strengthened consumer confidence, and an expanding GDP. Between 1995 and 2000, the unemployment rate had dropped from 8.7% to 5.6%, with a record 198,000 jobs created in 1999, almost all of which were full time positions. Housing starts (a key indicator of consumer confidence) increased by 24.9% in 1999, reaching a decade high of 67,235 units, while Ontario retail sales rose by 7.3% over the same time frame. The auto manufacturing sector, which accounted for nearly half of Ontario’s exports, increased production by 26 percent between 1998 and 1999 (Ontario Ministry of Finance, 2000). At the same time, a burgeoning knowledge-based, high tech sector was beginning to play a more significant role as a catalyst for economic growth: in 1999, telecommunications exports in Ontario grew by 12.3% in real terms, while computer exports increased by 18.1% (Ontario Ministry of Finance, 2000). One of the more notable innovators in Ontario’s high-tech sector, Research in Motion, launched the first BlackBerry smartphone in April 2000 (EndGadget, 2009).

But these positive trends were accompanied by a growing sense of unease among many Ontarians, who expressed concern that the wealth generated by an ever-expanding economy was not being distributed equitably, while years of neoliberal tax and spending policies at the federal and provincial levels were fuelling levels of poverty, homelessness and food insecurity that had not been witnessed since the 1930s. A sense of this discomfort pervaded the New Year's Day edition of the *Toronto Star*, which included an open letter to the first Toronto baby born in 2000. After the obligatory welcoming remarks, the content of the letter took a decidedly darker, dystopian turn:

"Because we're handing to you, little one, a world so divided by inequality - in wealth, in resources, in access to human rights - that you, not us, will not be able to ignore or isolate yourself from the chasm. It will suck you in..." (Hurst, 2000, A1, A22)

There was, in fact, ample evidence for concern about the rising levels of poverty and economic inequality in Ontario. During the mid-1990s, the after-tax income gap between the wealthiest and poorest 10% of Ontario families began to exceed the Canadian average and continued to do so over the ensuing decade (Yalzinian, 2007). The substantial reduction in social assistance levels combined with punitive measures that negatively impacted the working poor, such as a freeze in the minimum wage and the abolition of rent controls on new and vacant units, resulted in an additional 32,000 Ontario children living in poverty between 1995 and 1997: by 1997, Ontario had the highest rate of child poverty in Canada (Campaign 2000, 1999). In Toronto, over one third of children were living below Statistics Canada's low-income cut off (LICO) line (Campaign 2000, 1999).

The impact of social assistance cutbacks was especially onerous on families headed by single mothers. In the year following the reduction in social assistance rates, the percentage of single mothers in Ontario living on less than one half of LICO jumped from 10.2% to 12.2%

(National Council of Welfare, 1996). Many of those affected coped by depriving themselves of adequate nutrition. A 1997 study of 153 women using food banks in metropolitan Toronto found that 70% of single mothers had gone moderately or severely hungry over the past year, and 57% had experienced hunger during the past month. Over 60% reported cutting the portion size of their own meals due to lack of food (Tarasuk and Beaton, 1999).

The increasing socio-economic inequalities in Ontario, and their attendant impacts on health status, did not escape the notice of public health advocates. In an open letter to health promotion practitioners, Raphael (2001, p. 99) lamented that “*public health now focuses upon health protection issues related to air pollution and restaurant and nursing home inspections with little if any emphasis on issues of poverty and social exclusion.*” Others questioned whether a failure to adequately define the key tenets of health promotion had made it vulnerable to misappropriation by neoliberal interests whose policies were exacerbating health inequities. For example, a 2000 reflection piece on the state of health promotion in Canada observed that:

“the rhetoric of health promotion itself has not always offered a clear analysis of the determinants of health, thus opening it to being used and interpreted in a variety of ways, especially in the context of health reforms (e.g., restructuring, decentralization, amalgamation, de-insuring of services, managerialism).” (O’Neill, Pederson and Rootman, 2000, p. 138).

The public health sector itself was by no means exempt from provincial cost-cutting initiatives. In theory, public health’s position as a component of the provincial health care system might have afforded it some degree of immunity from funding reductions, as the *Common Sense Revolution* manifesto made an explicit pledge not to cut health care spending (Progressive Conservative Party of Ontario, 1994). However, Ontario was (and remains) the only Canadian province requiring municipal governments to share public health costs (Deber et al., 2006). During the fiscally prudent climate of the time, the dual municipal-provincial funding and

governance of public health units invariably gave rise to concerns about duplication, mismanagement and waste - all of which were anathema to neoliberal decision makers. In response to these concerns, the province introduced Bill 152, *The Services Improvement Act*, in early 1997. The Act called for the ‘downloading’ of responsibility for funding public health, long-term care, ambulance services, social housing and a greater proportion of social assistance costs to municipal levels of government in exchange for the province assuming full funding responsibility for education.

A subsequent analysis by Deber et al (2006) found that the downloading of public health in Ontario received almost no attention or ‘pushback’ by municipal authorities; in financial terms, outlays for public health services were regarded as small and predictable. A counter-proposal to Bill 152 by the Association of Municipalities of Ontario (AMO) accepted municipal responsibility for funding public health and ambulance services while proposing greater provincial responsibility for long term care and social assistance. After a period of negotiation between the province and AMO, a revised agreement was reached and Bill 152 was passed into law (Deber et al., 2006).

While the full downloading of public health costs to municipalities, which took effect on January 1, 1998, did not appear to negatively impact the health of Ontarians, the same could not be said of a concurrent policy decision that shifted responsibility for water testing to municipal governments. As was the case with public health, the government of the day did not see the need for significant provincial investment and oversight, assuming that private sector water testing laboratories could fill the void. Nor did they feel the need to maintain former reporting structures, including the circulation of water advisories to local health units. The end result of this policy was an outbreak of e-coli-infected drinking water that killed seven residents and

sickened thousands more in the Ontario municipality of Walkerton in May 2000 (O'Connor, 2002).

Just one year after the downloading of public health to municipalities went into effect, the inherent contradictions of provincial standard setting and local spending control were beginning to surface. Municipal governments were continually pressing the province to give them greater flexibility in the scope of public health programs they were required to provide (Deber et al, 2006). As a result, the Ontario government reversed its earlier position and agreed to fund 50% of public health costs in March 1999. In addition, the province gave municipal authorities greater ability to tailor programs in response to local needs (AMO, 1999). Although this compromise could be (and likely was) interpreted as a catch phrase for circumventing standards, the subsequent section demonstrates how it also provided a small number of health units with the flexibility to innovate in ways that ran counter to the neoliberal orthodoxy of their provincial funder.

7. Local Public Health Unit Actions Addressing the SDH (2000-2009)

7.1 Peterborough City County Health Unit (PCCHU)

i) Key Demographics at Time of Case

Peterborough County, the catchment area served by the Peterborough City-County Health Unit (PCCHU), is located in central-eastern Ontario. The county consists of eight townships and the city of Peterborough, with a municipal government independent of county administration (County of Peterborough, 2016). The population of Peterborough County in 2001 was 125,856, increasing to 133,080 in 2006 (Statistics Canada, 2006a).

The southern half of the County is predominantly agricultural, with several small urban communities. The northern part of the County, which encompasses the Kawartha Highlands Provincial Park, consists of lakes, rivers and diverse landscape and is predominantly used for seasonal recreational use (County of Peterborough, 2016).

The majority of Peterborough County residents, both during the time of the case and at present, reside in the City of Peterborough. With a population of 75,406 in 2006 (Statistics Canada, 2006a), the city serves as the hub for administration and services to the surrounding agricultural and forestry areas. During the time frame of this study, the City of Peterborough served as the Southern Region headquarters of Ontario's Ministry of Natural Resources, as well as two higher educational institutions: Trent University and Sir Sandford Fleming College. General Electric and Quaker Oats were the largest private sector employers, leading an industrial community centred on general manufacturing and food processing (Tomalty et al, 2007).

Population growth within the City of Peterborough was relatively low during the time of the case, increasing by less than 5 percent between 2001 and 2006 (Statistics Canada, 2006a). The flat population growth during this period was associated with corresponding deficits in the SDH, including a lack of market-rate rental housing and rates of unemployment and poverty that consistently exceeded the provincial average (Tomalty et al., 2007). A more detailed assessment of these factors is provided in the ‘problems stream’ section of this case study.

ii) Chronology of Events

PCCHU staff had a long history of collaborating with community groups on various initiatives focused on the SDH, especially food security and student nutrition. However, by 2000 many of these community partners were confronting PCCHU about the limitations of their traditional “lifestyle-oriented” approach to preventing chronic diseases. Rather than focusing their efforts on messaging exhorting Peterborough residents to “eat well, be active and stay smoke-free”, PCCHU was challenged to develop programming that more proactively addressed the SDH (PCCHU, 2006).

In response to this feedback, PCCHU staff began to participate in more ‘upstream’ community initiatives focused on the underlying social and economic conditions contributing to poor health outcomes. By 2002, PCCHU had representation on the Social Policy Initiatives Network (an advisory committee to the Peterborough Mayor and County Warden), the Peterborough Social Planning Council, and the Affordable Housing Action Committee. PCCHU also began to play a more active role in advocating for more equitable social welfare policies: in 2001-2002, it joined local and provincial organizations calling for an end to the claw back of the National Child Tax benefit by the Harris government (PCCHU, 2006, 2012).

To better determine how PCCHU could best address the SDH within the scope of its mandate, the Director of Health Promotion was given permission to attend the *Social Determinants Across the Lifespan* conference. This event, held at York University in November 2002, brought together over 400 Canadian health and social policy researchers and community representatives to: consider the state of ten key social determinants of health across Canada, explore the implications of these determinants on the health of Canadians, and outline policy directions influencing these determinants in order to improve the health of Canadians. Conference participants developed and endorsed the *Toronto Charter for a Healthy Canada* (see Appendix D), a consensus document calling for immediate and long term action on the SDH by all levels of government (Raphael and Curry Stevens, 2004). Dr. Dennis Raphael, a professor of Health Policy and Management at York University who organized the conference, was subsequently invited by the Director of Health Promotion to present to the PCCHU Healthy Lifestyles staff and to give the keynote address at the AGM of the Peterborough Social Planning Council in June 2003, an event attended by the Chair of the PCCHU Board of Health (PCCHU, 2012).

Beginning in 2003, an increased emphasis on the SDH by PCCHU was evidenced by a series of SDH-focused reports added to Board of Health meeting agendas. These included the first Board report focused on the SDH in Peterborough (April 2003), a discussion paper identifying low income communities as the primary audience for *Health for Life*, a provincially-funded heart health program operated by PCCHU (June 2003), and the results of an annual Food Cost survey (i.e., cost of a weekly basket of nutritious food) conducted by the PCCHU Nutrition Promotion program (September 2003). These reports laid the groundwork for the endorsement of the *Toronto Charter for a Healthy Canada* by the PCCHU Board of Health in October 2003

(PCCHU, 2012). This was subsequently identified as a key milestone, since it enabled PCCHU to explicitly dedicate infrastructure and resources to addressing the SDH (McKeen, 2015).

In November 2003, the PCCHU Management Team approved the terms of reference for the Health Unit's *Social Determinants of Health Committee* (SDHC). The Committee, with membership comprised of representatives from each department within the Health Unit plus a representative from *Health for Life*, held its first meeting in December 2003 (PCCHU, 2006).

An operational plan developed by the SDHC in February 2004 served as the key blueprint for PCCHU's SDH-focused activities until the introduction of the *Ontario Public Health Standards* in 2009. The goal of the plan was to ensure coordinated action and increased capacity for addressing the SDH across all Health Unit programs and services. Objectives of the plan included: ensuring that the SDH and their impacts were considered in programming and policy decisions, enabling staff to advocate for the creation of positive health promoting conditions, and to build and strengthen partnerships with organizations, coalitions and committees committed to action on the SDH (PCCHU, 2006).

An early priority of the SDHC was to ensure that all PCCHU staff had a requisite level of knowledge, skills and capacity to address the SDH in their roles. In December 2003, the PCCHU collaborated with the Peterborough YWCA on a successful Trillium Fund application, *Training for Possibilities*, to support SDH training for PCCHU staff and Board members. The training, which was based on previous anti-oppression curricula developed by the YWCA, was delivered through eighteen workshops reaching 233 participants in 2005-2006 (PCCHU, 2006, 2012). In addition to enhancing the capacity of existing staff for action on the SDH, PCCHU created a new

position, Health Promoter, Poverty and Health, with direct responsibility to develop health unit responses to poverty and low income, in January 2007.

The focus on advocacy as a priority for capacity development is reflected in PCCHU's increased involvement in direct advocacy for programs and policies addressing the SDH from the mid-2000s onward. In November 2004, PCCHU's Director of Health Promotion and key community partners, including the Social Planning Council, met with the local MP, Peter Adams, and MPP, Jeff Leal, to discuss the inadequacy of Ontario Disability Support Program (ODSP) rates and their impact on health. This was followed by a February 2005 meeting between the Medical Officer of Health, the local MPP and three SDHC committee members to discuss the public health implications of a review of employment assistance programs launched by the then Minister of Community and Social Services. During the 2007 provincial election, PCCHU and its *Health for Life* program sponsored the printing of local candidates' responses to questions on poverty reduction in both local newspapers. In 2008, the Poverty and Health Program, an initiative developed by the health promoter hired by PCCHU to focus on anti-poverty work the previous year, developed a series of TV ads on the importance of social policies and health to coincide with the October 2008 federal election. The ads were designed to steer viewers to the PCCHU website, where updates on all-candidates meetings were posted. In addition, PCCHU co-sponsored an all-candidates meeting, and placed a newspaper ad informing the public about each candidate's position on poverty and health (PCCHU, 2012).

Concurrently, the PCCHU Board of Health received a steady flow of reports addressing key SDH issues in Peterborough, such as poverty, food insecurity and lack of affordable housing, as well as specific policies (e.g., ODSP, Ontario Works, the Special Diet Allowance). In

December 2008, the PCCHU Board of Health endorsed the declaration of the “25 in 5” campaign and its objective of reducing poverty in Ontario by 25% over 5 years (PCCHU, 2012).

These advocacy efforts were complemented by a series of media activities aimed at increasing public awareness of the SDH and building support for policies to provide more equitable access to the social and economic pre-requisites for good health. In March 2004, the PCCHU partnered with a neighbouring health unit, Haliburton, Kawartha and Pine Ridge District Health Unit, to develop a media campaign addressing poverty and its barriers to health. The goal of the campaign was to increase awareness among community decision makers about the prevalence of child poverty and its impact on health. The campaign included a television commercial on child poverty that aired on the local TV station, CHEX, from January to November 2005. In September 2007, PCCHU worked with CHEX to create TV ads highlighting the need for programs and policies ensuring nutritious food, safe and affordable housing and an adequate income in order to have a healthy community. This media campaign also directed viewers to the PCCHU website for links to additional information and resources. PCCHU had initially updated its website in 2005 to include a section on the SDH (PCCHU, 2006, 2012).

In 2006, local political developments increased PCCHU’s profile as an organization committed to reducing poverty and income inequality. In November 2006, the newly elected Mayor of Peterborough, Paul Ayotte, announced his commitment to developing a municipal poverty reduction strategy (Anderson, 2006). To achieve this vision, he formed a Mayor’s Action Committee on Poverty in January, 2007.

Given its history of collaboration with key anti-poverty organizations in the community, it’s not surprising that the PCCHU was asked to play a major role in supporting the Mayor’s

Action Committee on Poverty. In May 2007, four PCCHU staff facilitated a series of consultations on food, housing, basic needs and income attended by over 480 Peterborough residents. Health unit staff also coordinated the election of four low-income representatives to the Mayor's Action Committee on Poverty in June 2007. PCCHU's Health Promoter, Poverty and Health, was nominated to represent the health unit on the Committee. Following the restructuring of the Mayor's Action Committee into the Peterborough Poverty Reduction Strategy in 2008, PCCHU's new Medical Officer of Health chaired the Food and Nutrition Workgroup. Other PCCHU staff participated on other committees created by the Poverty Reduction Strategy (PCCHU, 2012).

In addition to the aforementioned local achievements, PCCHU was successful in acquiring significant provincial resources for action on the SDH during the period covered by this study. In July 2006, the Ontario Ministry of Health Promotion set a precedent by approving a Peterborough *Health for Life* workplan focused solely on advocacy addressing the social determinants of health as opposed to the more traditional communication and awareness building activities addressing modifiable health behaviours (PCCHU, 2012). In August 2006, following a presentation by the PCCHU MOH, the Director of Health Promotion and senior staff to the Chief Medical Officer of Health, Dr. Sheela Basrur, PCCHU received one-time funding for *The Hunger Initiative*, a multi-component food security project. This project, which consisted of advocacy for anti-poverty initiatives, facilitated cooking sessions (including subsidized transportation and childcare for participants), the distribution of subsidized frozen meals and food boxes and the creation of food-related employment opportunities for participants, was subsequently funded by the Ontario Ministry of Health and Long Term Care through 2008 (PCCHU, 2007).

iii) Analysis of PCCHU's Actions on the SDH by Key Components of Multiple Streams Theory

The Problem Stream: Indicators of SDH Deficits

Data collected during the time of the case reveal considerable deficits in equitable access to the social determinants of health among residents of PCCHU's catchment area. The percentage of Peterborough City residents living in poverty (% of low income after tax) at the time of the 2006 census (12.6%) was higher than the Ontario average of 11.1%, although the poverty rate of the combined Peterborough-City and County (9.1%), which encompasses more affluent rural and semi-rural communities, was lower than the provincial average (Statistics Canada, 2006a). The 2006 census also revealed that an alarming 62% of single mothers with children under 6 were subsisting on low income in Peterborough City/County (Statistics Canada 2006a).

The high rates of poverty in PCCHU's catchment area, especially in the City of Peterborough, were evidenced by correspondingly high rates of food insecurity and lack of access to affordable housing. Data collected by the Canadian Community Health Survey (CCHS) in 2005 found that the prevalence of household food security in Peterborough (6.1%) was slightly higher than the provincial average of 5.9% (Statistics Canada, 2005). Among Peterborough's tenant households in 2001, 51.5% spent more than the benchmark 30% of income on housing, the highest in a sample of 27 Ontario municipalities; 33% spent more than 40% of income on rent (Tomalty et al., 2007).

The Problem Stream: Community Awareness

Community awareness about the extent of SDH deficits in Peterborough City/County at the time of the case was limited. One of the community advocates, who was instrumental in

encouraging PCCHU to be more proactive in addressing the SDH, did not feel that general awareness of the ‘upstream’ causes of ill health among Peterborough residents in the early 2000s was “*very high....I don’t think as a community there was a lot of thought given to that unless you put people in a position to ask them about it. Like what would you do if you lost your house?*”

One of the assets enjoyed by PCCHU is that the City of Peterborough is utilized as a training community for Statistics Canada (Post, 2015). As a result, the health unit is periodically able to insert health-related questions into interview training exercises. In 2006 and 2007, one such exercise included questions devised by the health unit to discern community awareness about the SDH. The PCCHU Health Promoter described the less-than-encouraging results:

“And what we found was that awareness was pretty low. When you asked people ‘what determines health?’ you know, hospitals, doctors, access to those kinds of services came out on top. But the really interesting thing is that we found that the higher your income, the less aware you were of housing and income and access to services being determinants of health.”

The results of this survey guided the development of the aforementioned 2007 and 2008 (election-focused) media campaign aimed at educating the public about the health consequences of poverty and the importance of healthy public policies to alleviate them. The PCCHU health promoter noted that the campaign ads were directed at the middle to high income residents who were less aware of the impact of the SDH on health (Post, 2015).

In addition to targeted campaigns, PCCHU staff made concerted efforts to raise community awareness of the SDH at every opportunity. In describing these efforts, the Director of Health Promotion noted that “*we always tried to be in the local paper. With a small health unit, it was easier and I had a number of connections....so we would get the paper to interview or go to a community garden or collective kitchen or whatever. And whether we were mentioned or not, I didn’t care. I just wanted to get it out there.*”

The ultimate impact of these efforts to raise community awareness about the SDH is unclear. Evaluations of the 2007 and 2008 media campaigns revealed an increase in hits on the SDH section of the PCCHU website: for a time the SDH page was the second most popular link on the PCCHU site. However, more sustained changes in public awareness, attitudes and support for SDH-friendly policies were not tracked due to inherent difficulties in measuring the impacts of small scale media campaigns (Post, 2015). In retrospect, the Health Promoter who played the lead role in developing these campaigns feels that they might have had a greater impact had their objectives gone beyond raising awareness and focused on more tangible outcomes that increased access to the SDH:

“I think those campaigns needed to be rooted in a particular community issue or a specific action associated with them - more than just awareness raising. I think they would have been more successful if they’d been linked to the creation of a housing plan or actually providing more emergency food support or something the community was involved in.”

The Problem Stream: Focusing Events and Feedback

Unlike some of the cases described in this study (e.g., Sudbury, Leeds Grenville and Lanark), there does not appear to have been any one discernable ‘focusing event’ that directed the PCCHU’s attention towards the SDH. Rather, PCCHU’s shift to SDH-focused initiatives appears to have been inspired mainly by the problem stream variable of community-level **feedback**, a growing concern by key community activists about the worsening socio-economic conditions in Peterborough City-County. A more detailed description of the means by which these individuals conveyed their concerns to PCCHU is described in the *Characteristics of Policy Entrepreneurs* section of this case study.

As a community suffering from high rates of poverty, food insecurity and homelessness, Peterborough City-County had been hard hit by the funding cuts of the Mike Harris/Paul Martin

era. The high percentage of total income derived from government transfers in Peterborough City-County - 15.4% vs 8.6% province wide - (Statistics Canada, 2001a, Tomalty et al., 2007) put the community in an especially vulnerable position during a time of extreme fiscal restraint. In particular, the impact of the Harris government's 21.6% cut to social assistance rates in 1995 still resonated over two decades later. When asked how long it took for Peterborough City/County to recover from the impact of the social assistance cutbacks, one community group respondent, who played a key role in creating the Mayor's Action Committee on Poverty, replied, "*the truth of the matter is, despite all of our efforts, we've never recovered.*"

There is, however, one possible event that may have prompted community activists to apply greater pressure on PCCHU to be more proactive in addressing the SDH than might otherwise have been the case, although it was only mentioned by one respondent. In Ontario, a network of community health centres (CHCs) provide primary care services in combination with health promotion and illness prevention initiatives with a focus on community development addressing social, economic and environmental problems negatively impacting people's health (Association of Ontario Health Centres, 2015). Peterborough, unlike other cities its size, has always lacked a CHC. Provincial approval to establish a CHC in Peterborough in the early 1990s was rescinded shortly after the Progressive Conservatives took power in 1995 (Favreau, 2016). Consequently, this may have put increased expectations on PCCHU to fulfil the SDH-related community development and advocacy roles that would have been assumed by a CHC. Specifically the respondent, who directed community development at the Peterborough YWCA and organized the 2005-2006 PCCHU staff training sessions on the SDH, notes that:

"So what it means is that maybe in other communities, the community health centre plays a strong role in putting forward a social determinants of health plan to the community at large. We

don't have that here. And so I think it has left the health unit with the opportunity to evolve in a way that may have been different had we had a community health centre."

Characteristics of the Policy Entrepreneurs

When considering the attributes of the key agents, or policy entrepreneurs responsible for enabling the shift towards SDH-focused initiatives, PCCHU differs from the other cases in one important respect: the key impetus for change came from key representatives of community organizations rather than from within the health unit itself.

As was noted previously, community partners involved in PCCHU's *Health for Life* and heart health programming were challenging the health unit for what was perceived as an overly reductionist approach to addressing chronic diseases. This discontent was described in both contemporary documents (PCCHU, 2006) as well as interviews conducted for this study. For example, the PCCHU Health Promoter responsible for overseeing poverty reduction efforts noted that *"We were very focused on 'eat well, be active, stay smoke free' messages, and it was community partners who sort of encouraged us to move away from that."* The then-public health nutritionist described similar dialogues with representatives of community organizations she encountered at meetings: *"People were telling us 'hey, you've got to work on income issues here. You're not going to get people to eat those lovely vegetables without working on income."*

The community partners found a receptive audience in the then-Director of Health Promotion, whom multiple respondents identified as the key policy entrepreneur and driving force in re-directing PCCHU towards action on the SDH. The then-public health nutritionist describes notes how the Director *"grasped the social determinants of health because she was*

managing the nutrition program at that time. So she got it. She became the conduit between what was happening in the community and the Board of Health and our MOH. So it was up to her to say 'ok, we have to address health more broadly'.”

Over the course of her interview, the Director of Health Promotion described how ongoing dialogue with community representatives brought about a shift in her own thinking about the SDH and motivated her to play a lead role in transforming the health unit:

“I think also I felt that how could we hold our heads up in public health and pretend this wasn't an issue? If we were going to work cooperatively with these community agencies, how could we ignore what they were seeing, what we were seeing and go about our business with any kind of integrity?...I probably ignored it for a while, thinking what can we do?....But as we became more aware, you couldn't ignore it. You've got to bring it to the attention of the politicians and the powers that be and build a business case for them.”

In her efforts to broaden the scope of SDH actions at PCCHU, the Director of Health Promotion benefitted from a high level of **political connectedness and negotiating skills**, one of the key attributes of successful policy entrepreneurs identified in multiple streams theory (Kingdon, 2011). Although the SDH had not been an explicitly identified priority within PCCHU prior to 2003, the health unit had engaged in extensive community work on food security going back to the 1990s, when staff played a key role of developing early prototypes of the Good Food Box program and the process for measuring the cost of a nutritious food basket (Hubay, 2015). Through this work, as well as their heart health and *Health for Life* initiatives, they had established close working relationships with a broad range of community groups, such as the Peterborough YWCA and Social Planning Council.

Consequently, the level of collaboration over time may, in turn, have fostered a level of trust and comfort that made key community leaders less reticent about pointing out the

limitations of PCCHU's programming to their public health partners. This view was confirmed by one of the community leaders identified as having prodded PCCHU to shift towards more SDH-oriented programming. When probed about how he 'confronted' PCCHU, he demurred, describing a process that was more cooperative than adversarial:

"Well, first of all I think I'd twist that around a little bit. I wouldn't want to say that, although I was part of a group that was doing it [pressuring PCCHU to address the SDH]....if anything, the leadership was coming from two of the staff at the health unit, who were kind of leading me in a way. So I was learning from them...As it evolved we sort of helped each other."

The Director of Health Promotion also had the benefit of a Medical Officer of Health (MOH), who was willing to support innovation in SDH-focused practice. Multiple respondents noted that while this individual, who served as the PCCHU MOH for most of the case (till 2007), did not play a lead role in initiating SDH initiatives, he was supportive of management and staff who were willing to do so. The PCCHU health promoter noted that *"Our MOH wasn't necessarily a lead in this area but he was interested and certainly willing to have information come to the Board and allocate resources."*

In their efforts to make the SDH an actionable priority by PCCHU, the Director of Health Promotion and key staff members demonstrated the quality of **persistence**, the willingness to invest significant amounts of time and resources into advancing an idea that Kingdon identifies as a key attribute of effective policy entrepreneurs (Kingdon, 2011). The Director described how she effectively utilized an incremental approach to persistence that gradually ensured that the SDH gained acceptance as part of the 'core business' of the Board of Health. This was accomplished, over time, by utilizing every opportunity to bring the SDH to the attention of the BOH:

“And the other thing I kept doing regularly - and I was insistent on it with the staff - was to highlight various aspects of the social determinants in our monthly board reports - what was happening with housing, what was happening with our food audit and our food action programs...I put a social determinants spin on all our reports....So when I would talk to board members about this, it was like ‘well, this is nothing new.’ We’ve been putting it in your board reports for years....And so we were able to tie all those kinds of projects in and keep building the case until it became the regular business of what we did at the health unit.”

The Politics Stream

All respondents felt that PCCHU’s SDH-focused activities enjoyed strong levels of support among the BOH, elected officials and key decision makers. In practice, this support gave PCCHU a high locus of control in determining how to best address SDH issues in the community. The Health Promoter responsible for coordinating anti-poverty efforts by PCCHU noted that *“both at a Director level and also at the staff level we were given a great deal of independence and autonomy to just go out into the community and make it happen.”*

Respondents attributed the favourable political climate to two key factors. One of these concerns the governance structure of the PCCHU BOH. PCCHU is one of 25 health units in the province with an autonomous Board operating separately from the administrative structure of its member municipalities with its own policies and procedures (Association of Local Public Health Agencies, 2015). The autonomous model allows for continuity of membership, ongoing board development and a staggered process of recruitment, which mitigates against complete turnover of Board members in the wake of municipal elections. In addition, autonomous Boards of Health also help to ensure the independence of the MOH, who reports directly to the Board without having to work through other bureaucratic structures (Capacity Review Committee, 2006). The current MOH of PCCHU views this structure as a key asset to PCCHU’s SDH work, noting that

“our Board of Health being autonomous has played an important role in enabling us to have an independent voice on the importance of addressing the social determinants of health.”

Second, PCCHU’s antecedent work in addressing food security during the 1990s, which culminated in the granting of multi-year provincial funding for its *Hunger Initiative* project, garnered a level of political capital and support at the Board level that eased PCCHU’s transition into other aspects of SDH-focused practice. The public health nutritionist, who was responsible for spearheading much of this work, noted that *“We had been talking about the nutritious food basket and the issues of income and food security at a Board of Health level for over a decade. So I think that when it came to the other determinants of health, especially around housing and income, they connected right away. So the other connections were easier to make by 2003.”* The current MOH agreed that the success of PCCHU’s earlier work on food security was a key factor in enabling PCCHU to shift its mandate towards the SDH:

“I think the fact that the health unit invested a great deal of time and energy on addressing food insecurity before I came...they did a great deal of advocacy on food security and were able to secure funding - not an insignificant amount of funding - to address food insecurity....and over time it created just enough momentum that we became seen as a real leader in the community on addressing poverty and food insecurity.”

The Director of Health Promotion leading PCCHU’s efforts to address the SDH did not take Board support for granted. She pursued an incremental strategy of **institutionalization** that began with getting the Board to endorse the *Toronto Charter for a Healthy Canada*, thereby giving its support for public health sector action on the SDH.

“So in September I did a presentation to the Board. That was September 2003....I sound like such a manipulator (laughs) but I left it hanging that we wanted them to endorse the Toronto Charter. I think we dangled that a little bit. Like wasn’t this exciting and wouldn’t it be great if we could endorse it? And there wasn’t time at that meeting....I got myself back to do a second presentation to the Board focusing on income and the Toronto Charter. And we had a motion set

up so that the Board unanimously passed the recommendations endorsing the Toronto Charter...one of the recommendations was to set up terms of reference for our own Social Determinants of Health committee.”

By including a recommendation to establish a designated committee within PCCHU to address the SDH, the Director thus ensured that the BOH’s support for SDH action went beyond token endorsement to include approval for a specific structure that, over time, institutionalized the SDH as a core element of public health practice within the health unit. In making the case to the Board, the Director was conscious of the fact that, while generally supportive, the Board included elected officials who were concerned about cost implications and keeping spending under control. This underscored her choice to adopt an incremental approach, with an initial focus on cost-free, albeit significant, ‘wins’:

“So I get it. They’re there to keep an eye on the board, not let us go crazy with spending, watch the taxpayers’ dollars...So that’s why I was so careful in building our case over the years on this issue. And the things we asked for initially, there was no cost. There was endorse the Toronto Charter and have staff form their own committee. So there was no cost to what we were asking for initially, and I kept building the case for saving taxpayer dollars by paying attention to the upstream issues.”

The Director also indicated the importance of negotiating skills and compromise in her efforts to increase PCCHU’s capacity for SDH action. In some cases, flexibility and creativity were needed to frame SDH solutions in terms acceptable to decision makers. As was noted previously, PCCHU’s resources for explicit action on the SDH underwent a considerable enhancement in 2006 when the Ontario Ministry of Health Promotion approved an advocacy-focused *Health for Life* plan as well as funding for the *Hunger Initiative* (PCCHU, 2012). However, approval for both of these initiatives required multiple proposal drafts and meetings with Ministry officials. The Director of Health Promotion recalled that *“in the Health for Life and food security programs, our plans had a huge social determinants of health focus and we*

didn't try to hide or bury it. And the Ministry didn't like it. They said 'we're not giving you money for food.' So we were as creative as we could be about coming up with the kind of cooking programs or community outreach they could support."

Over the duration of the case, two municipal-level political events enabled PCCHU to strengthen their focus on addressing the SDH. The first occurred in 2003, when the then-Chair of the PCCHU BOH ran for Mayor of Peterborough. This individual had become aware of the SDH and had attended Dr. Dennis Raphael's presentation at the Peterborough Social Planning Council's AGM in 2003. He subsequently asked the PCCHU Director of Health Promotion to give a presentation to the BOH on the SDH. The Director described this invitation as "*the opening I was really looking for*", as it set the stage for the subsequent adoption of the *Toronto Charter for a Healthy Canada* and the approval of the PCCHU Social Determinants of Health Committee by the Board (McKeen, 2015). Although his campaign for Mayor was not successful, the Councillor's interest in the SDH led to the BOH's endorsement of what became critical building blocks for PCCHU's SDH-focused activities.

The second event occurred in 2006 when another incumbent Councillor launched a successful campaign for Mayor. On election eve, the Mayor-Elect announced his commitment to a municipal poverty reduction strategy, telling a local newspaper reporter that "*We need a municipal poverty reduction strategy and I promised I'd do that within 90 days of being elected. We need to bring volunteers and community groups together to address poverty. We need to reduce the use of food banks, upgrade to better jobs and develop a housing strategy. I think it will make a difference.*" (Anderson, 2006 p. 1).

Two respondents noted that the idea of a coordinated municipal strategy to combat poverty in Peterborough did not originate with the new Mayor; rather, it was part of the platform of his principal opponent in the election and subsequently adopted by the Mayor Elect (Martyn, 2015; Favreau, 2016). The shared level of support for poverty reduction by municipal decision makers, even those competing for the same elected office, was a factor that favoured PCCHU's SDH-focused efforts going forward.

As was noted previously, PCCHU's history of advocacy and community engagement on SDH issues positioned it to play a key role in implementing the Mayor's vision through its work in supporting the Mayor's Action Committee on Poverty, which was subsequently re-branded as the Peterborough Poverty Reduction Network (PCCHU, 2012). Moreover, the fact that the Chief Magistrate of the largest city in PCCHU's catchment area was a champion of local poverty reduction efforts helped to create a political climate that enabled the health unit to expand its SDH-focused work. In the wake of the 2006 election, PCCHU was able to hire a full time health promoter to focus on anti-poverty initiatives and launch substantive community awareness campaigns addressing the SDH (PCCHU, 2012).

The Policy Stream

To develop a coordinated response to the SDH that spanned the range of core public health functions, the PCCHU Director of Health Promotion ensured that the newly formed Social Determinants of Health Committee (SDHC) included representatives from across the health unit, including health inspectors (McKeen, 2015). As was noted previously, the SDHC led the development of the first multi-year operational plan to address the SDH in February 2004.

The next challenge was to build the capacity of both the Committee and PCCHU staff to address the SDH in their scope of practice. In describing the Committee at the time of its inception in 2003-2004, the Director recalled that *“although we had very specific goals and objectives and tasks....it’s not as though it was a cohesive group or they believed in it [the SDH], I had a lot of work to do to bring them along. Because they didn’t get it yet....And I think a big piece of it early on was to educate the staff. That precipitated our work with the YWCA.”*

The overall goal of the training was to help PCCHU staff integrate the SDH into their programs and services (PCCHU, 2005). Funded by a Trillium Grant and delivered by YWCA staff, the training comprised of three series of workshops. The first series focused on issues of power, exclusiveness and inclusiveness in society. The second series of workshops, titled “Oh Gosh, I had No Idea!!!,” encouraged participants to consider the beliefs and stereotypes underlying the assumptions they make about themselves and others. The final sessions focused on advocacy, exploring the key steps of identifying an issue and audience, building a constituency, persuasion techniques, strategizing with allies, and appreciating the levels of patience and perseverance advocacy requires (PCCHU, 2012).

The team responsible for developing the training sessions took steps to ensure that the content was: compatible with the organizational culture of PCCHU, reflective of day-to-day ‘hands on’ experiences where staff would encounter SDH issues in their roles, and addressed both assumptions about the SDH (by staff and community members) and challenges encountered by staff in their efforts to take action on the SDH (Favreau, 2016). The YWCA Community Developer who facilitated the training sessions describes how these considerations were incorporated into the planning process:

“So we met with the various teams and we tried to get a sense of team culture...and then we tried to imagine what was the best way to integrate the social determinants of health training into the culture they already had? And what were the key issues that could become problematic? So we tried to do workshops that were very hands-on, very experiential....we had sessions where we also looked at assumptions. We tried to gather from staff, what were the challenges they were encountering? And we provided them with scenarios based on the stories they had shared.”

Evaluations of the workshops revealed an increase in staff awareness, knowledge and skills related to the SDH as well as a greater perceived integration of the SDH into the core functions of the health unit (Favreau, 2016). Anecdotal information also reveals how participants in the training became greater advocates for the SDH through interpersonal exchanges. For example, the Director of Health Promotion recollected an ‘a-ha’ moment shared by one of her staff following a YWCA training session: *“And there’s one person I remember.... she commented on being at a family dinner at Thanksgiving and something negative was said about people in poverty. And she said ‘you know, I really got it.’ And she took them on about whether they could even afford to eat or had a safe place to live or could cook.”*

In addition to building the capacity of staff to take action on the SDH, PCCHU focused on enhancing the capacity of community members, especially those living on low income, to participate in local efforts to provide more equitable access to the SDH. Key venues for achieving this objective included the multi-year, provincially funded *Hunger Initiative* and the Mayor’s Action Committee on poverty, which facilitated a series of consultations with low income residents and held elections (supervised by PCCHU) to elect low income representatives to the Committee (PCCHU, 2006, 2012). The then Public Health nutritionist describes how efforts to involve low income people yielded multiple benefits that included removing social and economic barriers to their participation in SDH actions, thereby giving them a voice in SDH-

focused civic engagement and increasing health unit understanding of their needs and perspectives:

“...we were finding subsidies to hire people or making sure that our hires for this specific program were people who had food skills but also had some issues around income levels....making sure people on low income were reimbursed for child care and income was given to them for being on the committees....we were acknowledging that income was key and their voices were heard through the process. It became more trusting when the professionals, or whoever we are called, started really saying that with confidence because people knew it was true.”

The operational plans developed by PCCHU to address the SDH are unique in their focus on advocacy as a strategy. To an extent that is not evident in the other cases analyzed in this study, PCCHU was explicit in both naming and embracing active advocacy by PCCHU staff as a means of ensuring equitable access to the SDH at the community level. For example, the original (2004) SDH operational plan identified staff advocacy *“for the creation of positive health promoting conditions”* as one of its objectives (PCCHU, 2006, p. 2), while a subsequent SDHC plan focused on poverty included a goal of supporting *“advocacy efforts to address the Social Determinants of Health in our community and at the Provincial and Federal level”* and a sub-objective *“to encourage and support advocacy efforts of Health Unit staff as opportunities arise”* (PCCHU, 2006, p. 6).

There is evidence that a favourable political climate enabled PCCHU to be more proactive in advocacy for policy change than other health units. Key elements of this political environment included an increasingly supportive BOH, strong support for SDH action by key community organizations, a local MP and MPP who actively aided the health unit in securing additional resources for SDH work, and a City of Peterborough Mayor who launched a municipal anti-poverty strategy (PCCHU, 2012). Moreover, key champions of SDH-focused work within the health unit described a willingness to take risks. One respondent recalled that

“we just ignored any messages we got that you were not allowed to advocate. Advocacy is important.”

Table 3: PCCHU Case Summary and Degree of Convergence Between Streams

Component of Multiple Streams Theory	Description
The problem stream	<ul style="list-style-type: none"> • significant evidence of community-level SDH deficits (poverty, food insecurity, access to affordable housing) • limited awareness of SDH in broader community, but local anti-poverty activists gave persistent feedback to PCCHU, encouraging the health unit to take action on ‘upstream’ causes of ill health • no single focusing event raising awareness of SDH in community • absence of community health centre (CHC) in Peterborough may have increased expectations for health unit to address SDH deficits
Characteristics of policy entrepreneurs	<ul style="list-style-type: none"> • impetus for change initially emanated from community partners rather than health unit itself • MOH of PCCHU did not play lead role, but remained supportive of SDH initiatives • Director of Health Promotion was key internal champion for change within PCCHU and demonstrated key attributes (persistence, political connectedness and negotiating skills) in bringing about change
The politics stream	<ul style="list-style-type: none"> • favourable political climate, including autonomous BOH and supportive BOH members • Director of Health Promotion pursued incremental strategy of institutionalization (Board endorsement of positions that enabled development of SDH-specific capacity and administrative structures within PCCHU) • 2003 and 2006 municipal elections in City of Peterborough raised awareness of SDH and increased political support for SDH actions by PCCHU
The policy stream	<ul style="list-style-type: none"> • establishment of committee with representation across PCCHU functions to coordinate SDH work • capacity building sessions enabling staff to address SDH within their scope of practice • policy solutions included efforts to build capacity of marginalized community groups (e.g., those living in poverty) • political/administrative climate enabled PCCHU to engage in SDH-focused advocacy
Evidence of stream convergence (coupling)	<ul style="list-style-type: none"> • partial convergence of problem and politics streams that enabled development of policy solutions over time

7.2 Leeds, Grenville and Lanark District Health Unit (LGLDHU)

i) Key Demographics at Time of Case

Leeds, Grenville and Lanark is a tri-county area of Eastern Ontario with a combined population of 159,101 at the time of the 2001 census (Statistics Canada, 2001b). The area is primarily rural, with a number of small municipalities. The largest municipality in the district is the City of Brockville, with a population of 21,375 in 2001 (Statistics Canada, 2001b).

The economy of Leeds, Grenville and Lanark at the time of the case was relatively diverse, comprised of agriculture, natural resources, manufacturing (centred primarily in Brockville and Smiths Falls), tourism and service-based companies (Economic Growth Solutions Inc., 2002). By the early 2000s, LGL residents, especially those in Lanark and North Grenville, were also benefiting from increased economic opportunities in the nearby City of Ottawa, fuelled in part by an emergent high tech sector. In 2001, over 40 percent of the working population of communities in LGL living within an hour's drive of Ottawa were employed within the national capital region (LGL Health Forum, 2001).

Key indicators of equitable access to the SDH in LGL at the time of the case are decidedly mixed. In 2001, the median income of all LGL households (\$48,666) was significantly lower than the Ontario average of \$53,626 (Statistics Canada, 2001b). Conversely, the percentage of private low-income households in LGL (9.8%) was slightly lower than the Ontario average (10.8%), as was the percentage of children living in poverty: 11.8 in LGL vs. 12.9% Ontario-wide (Statistics Canada, 2001b). Although the unemployment rate in LGL had experienced a sharp uptick in the early to mid-1990s, increased economic opportunities from the late 1990s onward, especially for LGL communities within driving distance of Ottawa, resulted

in an unemployment rate (5.9%) that was slightly below the provincial average (6.1%) by 2001: (Statistics Canada, 2001b).

A key demographic concern in LGL during the early 2000s was a significant elderly population of individuals aged 65 plus (15.9% in 2001) that was well in excess of the provincial average of the provincial average of 12.9% (Statistics Canada, 2001b). There was some concern about the capacity of the local health care system to meet the health needs of an aging population: the Brockville area of LGL had been officially designated as under-serviced, although there were limited data concerning the adequacy of access to health care in the entire LGL district (LGLDHU, 2000).

Transportation was identified as a major SDH deficit. With the exception of Brockville, the lack of a public transportation system in LGL limited access to health and social services within the tri-county area as well as neighbouring cities such as Ottawa and Kingston (LGL Health Forum, 2001).

ii) Chronology of Events

In early 2000, the directors of several health and social service organizations in LGL, including the MOH of the LGLDHU, identified a need to meet on an ongoing basis for intersectoral collaboration and planning. This led to the initiation of the LGL Health Forum, with representatives from over 80 member agencies attending the inaugural meeting in the spring of 2000. Participants spanned a diverse range of stakeholder groups, including local hospitals, townships, Children's Aid Societies, mental health and addiction services, public libraries, United Way boards, and health related charities and NGOs (Gardner, Arya and McAlister, 2005).

In October 2000, the LGL Health Forum met to review a presentation by the MOH on the health status of LGL residents. The Forum resolved to develop a coordinated, intersectoral strategy to address the population health deficits identified by the MOH. Support from the (then) Southeastern Ontario District Health Council (also a member of the LGL Health Forum) and the Ontario Ministry of Health and Long-Term Care enabled the Forum to develop a five-year (2001-2006) health improvement strategy that served as an operational framework for coordinating the Forum's efforts to address the SDH (LGL Health Forum, 2001; Gardner, Arya and McAlister, 2005).

The Forum's health improvement strategy, which was released and adopted by the Forum in the spring of 2001 identified three priorities for action: healthy lifestyles and behaviours (defined as tobacco, diet physical activity and self-esteem), the social and economic environment, with an emphasis on reducing poverty and its health effects, and access to health care, with an emphasis on improving access to primary/preventive services. To coordinate action on these priorities, the strategy called for the formation of a Forum Steering Committee supported by two sub-committees: one addressing the SDH (The Socio-economic issues Subcommittee) and one addressing equitable access to health care (LGL Health Forum, 2001). In addition, the Steering Committee was charged with maintaining communication with the multi-agency Tri Health Team (the then-heart health coalition for LGL), thereby ensuring Forum involvement in all three priorities (LGL Health Forum, 2001).

Negotiations with the Southeastern Ontario Regional District Health Council and the Ministry of Health and Long-Term Care led to the allocation of \$97,000 to support the first year's implementation of the Forum's Health Improvement Plan. This funding enabled the

Forum to hire a Health Planner to coordinate and support the operationalization of the Plan and LGL Forum activities (Gardner, Arya, and McAlister, 2005).

With support from the Health Planner and the MOH of the LGLDHU, the Socio-Economic Issues and Access to Health Care subcommittees collected, assessed and presented LGL-specific data regarding their respective mandates at Forum meetings in October 2002 and May 2003. The general membership of the Forum provided feedback on these findings and directed the sub-committees to proceed with the development of action plans.

In October 2002, the LGL Health Forum endorsed the following actions proposed by the Socio-Economic Issues Sub Committee and the LGL Tri-Health team:

- to write the provincial Minister of Finance opposing the “claw back” of the National Child Benefit Allowance;
- to write the federal Minister of Finance opposing a tabled bill restricting eligibility criteria for disability pensions;
- to develop municipal by-laws prohibiting smoking in all indoor public places and workplaces.

All of these actions were implemented, although the Forum was not successful in securing passage of the anti-smoking bylaws due to opposition from local councils (Gardner, 2015). A further recommendation to develop strategies addressing barriers in access to health care in LGL, proposed by the Access to Health Care Subcommittee, was approved by the Forum in May 2003. However, this recommendation was not fully implemented due to the loss of funding for the Health Planner in the spring of 2003 (Gardner, Arya and McAlister, 2005).

General membership meetings of the Forum were held on a semi-annual basis from 2000 to 2003. In addition to overseeing the development of the Health Improvement Plan and

approving the recommendations of the two sub-committees, these meetings enabled members to keep abreast of key developments in the LGL health sector. Representatives of LGL's two District Health Councils (Southeastern Ontario and Champlain District) were invited to present to the Forum, as was the Eastern Regional Office of the Ministry of Health and Long-Term Care. Health Forum presentations also touched on health reform initiatives, such as the Romanow and Kirby Commissions. To raise awareness of the health impacts of the SDH among Forum members, Dr. Dennis Raphael made a presentation on the negative impacts of poverty on heart health (Gardner, Arya and McAlister, 2005; Gardner, 2015).

Between 2002 and 2003, the LGL Forum was successful in identifying SDH priorities and maintaining a high degree of fidelity in implementing initial action steps. Unfortunately, funding for the Forum, which supported the work of the Health Planner, was not renewed in the spring of 2003. As a result, attendance at meetings fell below quorum (Gardner, Arya and McAlister, 2005). Efforts to secure alternative funding proved to be unsuccessful (Marshall, 2015), and the LGL Health Forum suspended its activities in September 2003.

iii) Analysis of LGLDHU's Actions on the SDH by Key Components of Multiple Streams Theory

The Problem Stream: Indicators of SDH Deficits

The creation of the LGL Health Forum was preceded by the release of a comprehensive population health status report by the LGLDHU. This report noted a 5% increase in all-cause, age adjusted mortality rate (748.1 to 786.5 per 100,000) between 1991 and 1995 (LGLDHU, 2000), which stood in sharp contrast to a declining age adjusted mortality rate for the province (685.2 to 677.6 per 100,000) during the same time frame (Ontario Ministry of Health, 1999). The

same pattern of increasing mortality in LGL exceeding the provincial trends was also noted for the two main categories of disease: cardiovascular disease and cancer (Ontario Ministry of Health, 1999; LGLDHU, 2000).

The health status report noted that these disturbing trends coincided with a three percent increase in the proportion of LGL residents living below the LICO cut-off point between 1991 and 1996 (Statistics Canada, 1996). However, this situation appears to have improved by the time of the 2001 census. In addition, the proportion of single parent families in LGL, who are at greater risk of living in low income households, increased between 1991 and 1996 (9.9 to 11%), although this figure remained below the provincial average (Statistics Canada, 1996; LGLDHU, 2000).

The prevalence of unhealthy behaviours in LGL, especially tobacco use, was also cited as a factor contributing to the unfavourable population health status indicators revealed by the report. Using 1996 Ontario Health Survey data, the LGLDHU noted that tobacco use in southeastern Ontario, the geographic area encompassing LGL, was 10 percentage points greater than the provincial average (Statistics Canada, 1997). LGL residents were also identified as being at greater risk of morbidity and mortality from other health-related behaviours, such as high fat consumption and reduced physical activity (LGLDHU, 2000).

The Problem Stream: Community Awareness

All of the respondents interviewed for this case study agreed that general awareness of the SDH among LGL residents was low. This lack of awareness, in part, was exacerbated by a conservative political culture in LGL. In commenting on the level of community awareness at the time of the case, the then-MOH of the LGLDHU observed that *“I would say the awareness*

in the community was very low. I still don't think it's very high in the community at large. I would say the prevailing values would have been counter to what we know to be true about the social determinants of health."

Although public awareness of the SDH, and their attendant impacts on health, appears to have been low, respondents noted a growing awareness of the concept among health and social service professionals in LGL. For example, the then CEO of the Brockville General Hospital, who chaired the LGL Forum Access to Health Care Subcommittee recalled encountering the term 'social determinants of health' *"probably in strategic planning exercises in the mid-1990s if not even a little before that...it was in the literature at the time and there were discussions at conferences and that sort of thing....in the health community it [the SDH], would be discussed at senior levels.* The then-Executive Director of the Family and Children's Services of Brockville, who chaired the Socio-Economic Subcommittee of the LGL Health Forum, concurred with this view, noting that, *"the professional community, I think, had information about it [the SDH]... awareness amongst the professional community was developing."*

This growing awareness of the SDH among health and community service providers in LGL, in turn, may have increased their receptivity to participating in an SDH-focused, intersectoral Health Forum at a time when health unit data indicated that the population health status of LGL had taken a turn for the worse. The LGLDHU MOH recalls that *"the Health Forum was made up of the leaders of health and social service agencies. And I think for them it was an easy sell. Like where I was saying that awareness about the social determinants of health was generally low, it was very high in that group....it was very easy to get them together as a group to look at this data and adopt a social determinants of health paradigm to take action."*

The Problem Stream: Focusing Events and Feedback

Respondents pointed to the aforementioned release of the LGLDHU population health status report, which revealed an increase in age-adjusted mortality among LGL residents and linked this trend to SDH deficits, as the key **focusing event** precipitating the creation of the LGL Health Forum. The MOH described how he used the report as an entry point to raise the idea of the Forum.

“So when we had data that showed that our health status had actually taken a negative turn during the preceding decade, correlated in time perhaps with a downturn in the economy and the beginning of Conservative government policies -well, I said what can we do? How can we be creative? So we created this Forum to try to do that.”

Although the LGLDHU health status report did not generate extensive media coverage in the community, it had caught the attention of the local health and social service leaders. As a result, it generated **feedback**, one of the necessary pre-conditions for action within the problem stream (Kingdom, 2011). Specifically, community stakeholders in the health and social services sector realized that the failure to adequately address the SDH through intersectoral action was compromising community health status (Marshall, 2015; Pickens, 2015). In some cases, community leaders consented to participate in the Forum with the knowledge that a) the issues addressed by the Forum did not directly relate to the mandate of their organization and b) the ‘success’ of the Forum, given its focus, would be incremental if not intangible. For example, the CEO of the Brockville General Hospital described the considerations that factored into his decision to participate in the Forum and assume a leadership role:

“I thought it was valuable for the hospital to be there because we were the people who looked after the fallout when the social determinants of health were not in good shape....I would say there probably wasn’t a direct link from what the Forum was doing to our day to day services. It

was more thinking in the future that if things were able to be improved in the [LGL] counties then long-term there might be less need for acute care services, recognizing we're probably talking ten or twenty years out."

The release of the LGL health status report also coincided with a growing concern about the cumulative impact of funding cuts, which reduced the capacity of key service providers in an area already challenged by geographic isolation and limited service access (LGL Health Forum, 2001; Economic Growth Solutions, 2002). Over time, the ongoing climate of fiscal restraint sparked an increased interest in greater collaboration and coordination of services within LGL.

The Chair of the Socio-Economic Subcommittee of the LGL Forum observed that:

"I think that there was a willingness in the community for this [the LGL Health Forum]. I think there were agencies that were struggling financially that needed to coordinate services in a more efficient way, and I think there was a willingness to do that....There were some pretty severe funding cuts at that point in time, and I hesitate to call that an asset. But it did force a level of cooperation and coordination that had not been necessary or existed prior to that."

Characteristics of the Policy Entrepreneurs

The MOH of LGLDHU during the time of the case (2000-2003), who served as the catalyst for the LGL Health Forum, was recognized as possessing **claim to a hearing**, the requisite authority and credibility of a policy entrepreneurs to serve as a spokesperson for a policy issue (Kingdon, 2011). The Chair of the Access to Health Care Subcommittee described how the MOH was a natural fit for directing the LGL Health Forum:

"I think the fact that it was being led by the health unit was important. It wasn't one of the acute hospitals or something like that leading it. It was the Medical Officer of Health...It was his focus and that was the way he felt public health should work."

Unlike the initiatives described in the other local case studies, the establishment of the LGL Health Forum was not contingent upon the approval of the LGLDHU's BOH. This was, in part, because the budget sustaining the Forum came from the local District Health Council rather

than the BOH (Gardner, Arya and McAlister, 2005; Gardner, 2015). Moreover, the MOH, exercising his claim to a hearing, felt that his role in supporting the LGL Health Forum was within his mandated role as a guardian of the community's health:

“I informed them [the BOH] of the fact it was happening, but I didn't seek their approval. I guess I considered my time to be - as long as it was actually spent on public health matters - for me to determine. As long as they were aware of what I was doing they would have had the opportunity to speak out against it or prohibit it if they so chose. But I wasn't going to ask them for permission to spend my time working with leaders of other agencies with a grant from another agency - namely the District Health Council - to take action.”

The extent to which the MOH and the other community leaders who organized the LGL Health Forum displayed the other two attributes of policy entrepreneurs, **political connectedness and negotiating skills** and **persistence** (Kingdon, 2011), is more difficult to ascertain. This is due to the fact that the LGL Forum operated for a relatively short period of time (3 years). Most of the first year was focused on generating the priority setting document, while the second and third years focused on planning, team building and low-level advocacy initiatives (e.g., letter writing). Given its voluntary participation, modest budget, support (albeit short-lived) from the local District Health Council and lack of formal mandate for resource allocation and service planning, the LGL Health Forum did not give rise to conditions requiring extensive negotiating skills or persistence on the part of its champions.

There is certainly some evidence that the Health Forum served to increase the **political connectedness** of the participating policy entrepreneurs. Both of the community representatives interviewed for this case study identified increased inter-agency communication and coordination as the key benefit of the Forum. The Chair of the Socio Economic Sub Committee felt that the Forum helped to break down *“the kinds of silos of services that we engage in - that each agency is an entity unto itself and each agency doesn't know what the other agencies are*

providing in terms of services...I met people and found out about services that I didn't know existed in the three counties and outreached with professionals and was able to share that information in a better way with my agency. The Chair of the Access to Health Care Subcommittee shared this viewpoint, noting that the LGL Health Forum “*was very good in that it engaged a broad group of organizations...it got people together in a room who historically didn't do that. The housing person and the hospital person hardly ever saw each other.*”

The Politics Stream

The political environment in LGL during the time of the case was decidedly to the right of centre. A Progressive Conservative who held several cabinet posts in the Harris and Eves administrations, served as the MPP for Leeds-Grenville during the time the LGL Forum was active. At the federal level, the Canadian Alliance, the successor to the Reform Party, had a powerful presence in LGL: in the 2000 federal election the Canadian Alliance candidate was elected in Lanark-Carleton (which included the City of Brockville), while the Canadian Alliance candidate in Leeds-Grenville came within 55 votes of unseating the Liberal incumbent (Elections Canada, 2016).

At the provincial level, the LGL Health Forum coincided with the final years of the Progressive Conservative government (2000-2003). In practice, this meant that the Forum did not operate in a political climate that was conducive to SDH-focused advocacy efforts. One respondent recalled that “*we had a Conservative government that was not going there. It was going in opposite direction.*”

As was noted previously, the links between political decisions, SDH deficits and negative health impacts created **focusing events** that led to the development of the LGL Health Forum.

The political climate also impacted the effectiveness of the Forum, as it was unsuccessful in securing the passage of smoke-free space bylaws in LGL, one of its key priorities, due to concerns about negative economic impacts for bar and restaurant owners in the district (Gardner, 2015). It could also be argued that factors in the politics stream affected the duration of the Forum, as the provincial grant, which supported the work of the Health Planner, was discontinued in the spring of 2003. However, the grant was allocated as one time funding with no assurances of renewal (Gardner, Arya and McAlister, 2005).

One respondent, the Chair of the Socio-Economic Subcommittee, felt that the LGL Health Forum would have had a greater impact if it was empowered with a more explicit political mandate to coordinate the planning and delivery of community services. Although the Forum fostered closer collaboration among service providers, the lack of formal directives from funders and the fact that participation in the Forum was voluntary limited its impact in breaking down the silos and levels of ‘territorialism’ among the key organizations addressing the SDH in the community:

“Everybody talks about coordinating, providing services in a more streamlined fashion. But when it comes time to actually implement, it takes more forceful outside leadership to say ‘this must be done!’...every organization that was involved with it [the Health Forum] saw it as an important coalition with the capacity to make changes. But it was entirely voluntary participation and it didn’t have much authority. It was still organizations functioning independently of each other coming together to talk....it generally needs a little more impetus than that.”

The Policy Stream

At the time of the case, the public health sector in Ontario lacked **clarity of directives**, the feasible, evidence-based policy solutions needed for effective action on the SDH (Exworthy,

2008). With the exception of the Equal Access Standard, *The Mandatory Health Program and Services Guidelines* (MHPSG), the document specifying the mandate of public health units in Ontario from 1998 to 2009, did not explicitly address the SDH (Ontario Ministry of Health, 1997). The ambiguity of the guiding principles underlying the document, combined with the scope and complexity of the SDH, led the MOH to conclude that a collaborative approach involving agencies addressing SDH within the community was more appropriate than a top-down initiative led by the health unit (Gardner, Arya and McAlister, 2005; Gardner, 2015).

The Health Planner was integral to maintaining the **capacity** of the LGL Health Forum. She enabled the Forum to make evidence-informed decisions using local data and provincial trends and led the implementation of Forum priorities. The MOH underscored the importance of having a full-time, dedicated resource person supporting the Forum's work: *"I believe very much in what I call 'the committee and the one'everybody's working off the corner of their desks with their day job. So you need a dedicated person, at least....to actually carry out the work of the committee. So a committee can come together to try to get things happening, but if they don't have a dedicated staff to action everything, it'll fall apart.* Which, as the MOH went on to note, is exactly what transpired when the funding for the planner was withdrawn in 2003: *"we lost the planner and then I would say we lost the active and ongoing support of the membership. I would say that sustainability was the ultimate challenge for the group."*

The LGL Forum did not pursue SDH-focused actions beyond intersectoral planning and advocacy. This is, in part, attributable to the fact that SDH-focused public health practice, and the resources and supports directing it, were relatively nascent when the Forum was created. Reflecting on the Forum, the MOH noted that its status as an early adopter served to limit its menu of SDH-focused activities:

“It was fairly early days and there wasn’t a lot I was aware of that was happening in the province on the social determinants of health. There certainly isn’t the infrastructure there is today, federally or provincially. We did not have Public Health Ontario. We did not have the Public Health Agency of Canada. We did not have the regional [National Collaborating] resource centres that exist around the country. Therefore, we did not have their research and products that now exist to support health unit activity. And we did not have content in our then Mandatory Program Guidelines to support action. So we were early.”

Table 4: LGLDHU Case Summary and Degree of Convergence Between Streams

Component of Multiple Streams Theory	Description
The problem stream	<ul style="list-style-type: none"> • LGL Health Forum linked to two focusing events: release of health status report linking increased numbers of LGL residents living below the poverty line (LICO) linked to increase in all-cause age adjusted mortality and worsening population health outcomes • focusing event accompanied by growing concern about funding cuts limiting the capacity of local health/social service providers to address the SDH, thereby increasing support for intersectoral action • low community awareness of SDH outside of network of health/social service professionals
Characteristics of policy entrepreneurs	<ul style="list-style-type: none"> • LGLDHU MOH recognized as possessing claim to a hearing, the necessary authority/credibility to lead the Forum and serve as key advocate for SDH actions. • LGH Health Forum increased the political connectedness of key community stakeholders supportive of SDH-focused initiatives
The politics stream	<ul style="list-style-type: none"> • local political culture distinctly conservative, right-of-centre and served to limit the impact of the Health Forum (i.e., inability to pass local tobacco bylaw) and may have affected duration of Forum • LGL Forum was led by the LGLDHU MOH, but was not funded or staffed by health unit beyond MOH participation. • some feeling that more formal political mandate for inter-sectoral planning and resource allocation would have strengthened the impact of the LGL Health Forum
The policy stream	<ul style="list-style-type: none"> • dedicated health planner (funded by District Health Council grant) critical for sustaining capacity of forum • Forum focused mainly on intersectoral planning and a limited degree of advocacy • breadth of SDH-focused initiatives constrained by Forum mandate and developmental nature of SDH-focused health unit practice over the course of the Forum's existence (2000-2003)
Evidence of stream convergence (coupling)	<ul style="list-style-type: none"> • partial convergence of problem and policy stream (focusing events increased support for SDH-focused intersectoral collaboration brokered by LGLDHU) • political stream may have limited scope and duration of LGL Health Forum

7.3 Region of Waterloo Public Health (RoWPH)

i) Key Demographics at Time of Case

Situated in the extended ‘golden horseshoe’ area of south-western Ontario, Waterloo Region is a regional municipality with a recorded population of 478,121 in 2006, an increase of over 40,000 since the 2001 census (Statistics Canada, 2006b). Encompassing an area of 1,368 square kilometres, the Region is composed of the cities of Cambridge (120,000), Kitchener (205,000) and Waterloo (97,000), and four rural townships (Statistics Canada 2006b; Tomalty et al, 2007).

Waterloo Region’s economy at the time of the case was highly diversified. Manufacturing was a key component of the Region’s economy: in the Kitchener Census Metropolitan Area (CMA), automotive-related manufacturing and metalworking employed over 9% of the workforce in 2004, and Toyota Motor Manufacturing was the largest private employer in the Region (ICAP, 2004; Tomalty et al., 2007) Other important economic clusters (with over 3% of local employment) included education, insurance, high tech, and financial services (ICAP 2004). Waterloo Region’s two universities, the University of Waterloo and Wilfrid Laurier University, had gained international attention as incubator hubs for many spinoff businesses, especially in the high tech sector. One notable example at the time of the case was Research in Motion, a firm employing over 3,000 employees that was enjoying robust growth on the strength of its *Blackberry* smart phone sales (Research in Motion, 2007; Tomalty et al, 2007).

The Region experienced significant economic growth during the time of the case: From 2001 to 2006, the total employed labour force in Waterloo Region rose by 11%, outpacing a 9% population growth over the same time frame (Statistics Canada, 2006b). However, the benefits of

this growth were not equitably distributed. Full time employment (defined as more than 30 hours worked per week) between 2001 and 2006 actually decreased by 14%, while part time employment increased over the same timeframe by 112% (Regional Municipality of Waterloo, 2011). The growing disparity between full and part time employment opportunities was, in part, attributable to a loss of over 2,020 manufacturing jobs in the Region between 2001 and 2006 due to the inability of established industries, such as textiles, tires and footwear, to compete with jurisdictions offering lower production costs (Canadian Auto Workers Union, 2008; Regional Municipality of Waterloo, 2011). While the economic boom in Waterloo Region had resulted in average incomes that were 10% higher than the national average in 2001, the average income of poor families in the Region was 17% lower than the national mean (MacKeigan, 2004).

The rapid growth and urbanization of Waterloo Region during the time of the case also gave rise to a range of SDH-related concerns related to the ability of the Region to meet the needs of a rising population. These included: a lack of youth services and a corresponding increase in youth crime, affordable housing, access to public transportation, a high rate of unemployment among a growing population of new Canadians, and the sustainability of the local ecosystem and local food production (Tomalty et al., 2007).

ii) Chronology of Events

In mid-1999, the Department Leadership Team (DLT) of the Waterloo Region Community Health Department, which was subsequently re-named the Region of Waterloo Public Health (RoWPH), was faced with the need to re-align its departmental resources to accommodate the introduction of the provincial *Healthy Babies Healthy Children* program. Rather than focusing solely on one change, however, the DLT saw the re-structuring as an

opportunity to shift resources towards planning and policy work addressing the social, economic and environmental conditions affecting health (Waterloo Region Community Health Department, 2001).

When considering the optimal re-alignment of RoWPH to support SDH-focused work, the DLT noticed that *The Mandatory Health Program and Services Guidelines* (MHPSG) were written a way that encouraged programs to evolve independently of one another. The DLT recognized that strategies addressing as broad a range of factors as the “determinants of health” could not be placed within the purview of an isolated “unit” within RoWPH. Accordingly, the new Health Determinants Planning and Evaluation Division (HDPED) was positioned as a cross-functional team supporting the work of other health unit programs. With the support of its Human Resources Department, the DLT identified two mutually reinforcing priorities to guide the work of the Division. First, dedicated resources were needed to coordinate research, evaluation and planning activities to ensure that policy and program development decisions were guided by the best available evidence. Second, increased capacity, both within RoWPH and the broader community, was needed to undertake healthy public policy initiatives (Waterloo Region Community Health Department, 2001; Schumilas, 2006).

On September 26, 1999, all RoWPH staff received the following email from the MOH describing the reorganization:

“It is realized that our health department needs to take more initiative in the area of Health Determinants, and that until and unless we actually allocate resources to this area, we will not be successful in our results to the extent we would like...There are many ‘root’ issues facing the health of the residents of Waterloo Region, and until we take the ‘bull by the horn’ and face these issues directly, we will not be able to affect changes in health.” (Waterloo Region Community Health Department, 2001, p. 3).

The HDPED of RoWPH was established in November 1999, with 20 positions and a budget of \$1.7 million (Schumilas, 2006). The goal of the Division was “To increase the collective capacity and staff and citizens to develop policies and programs which address the social, economic and environmental conditions that affect public health” (Schumilas, 2006, p. 178). This goal was to be achieved through the organization of the HDPED into three inter-related teams: Planning and Evaluation, Epidemiology and Data Management, and Healthy Communities and Policy (Schumilas, 2006).

During its first full year of operation (2000), the HDPED focused mainly on developmental activities, including staff and managerial recruitment, orientation, networking meetings, conceptual work, budget development and planning retreats. Two complementary frameworks were identified as critical for the identification of Division priorities. First, a community health indicators document, *Indicators That Count!* (Hancock, Labonte and Edwards, 1999), was used by Division staff to identify the SDH-related conditions that could be modified through a focus on healthy public policy. Second, the *Ottawa Charter for Health Promotion* (WHO, 1986), with its focus on strategies as opposed to outcomes, was adapted by the HDPED to identify four change strategies for addressing the social, economic and environmental conditions affecting health: i) citizen engagement, ii) evidence-based planning and development, iii) building the policy advocacy skills of change agents, and iv) building organizational supports for policy/advocacy work (Waterloo Region Community Health Department, 2001).

Staff from the Epidemiology and Data Management Unit of the HDPED supported RoWPH staff and community groups with health-related data requests and analyses. Division staff produced a series of data-based reports called “*Public Health Perspectives*”. These reports focused on a range of SDH topics in Waterloo Region, including child health, the health status of

immigrants, and food access. The distribution of these reports, coupled with geographic data mapping support from the HDPED, enabled community groups in Waterloo Region to play a more informed and proactive role in advocating for healthy public policies at the local level (Schumilas, 2006, 2015; Seskar-Hencic, 2015).

In addition, the HDPED collaborated with a consortium of agencies in Waterloo Region to analyze, interpret and share local data related to the SDH. In the fall of 2000, this consortium produced a series of fact sheets titled “Let’s Talk About Poverty”, which contained a mix of local statistics, stories from people living in poverty and local resources (Waterloo Region Community Health Department, 2001). A subsequent series of fact sheets on immigrants, health and employment guided local advocacy efforts regarding the recognition of foreign-trained professionals (Schumilas, 2006).

Efforts to build the policy change and advocacy capacity of community groups were not limited to data support. Beginning in 2001, the HDPED collaborated with Wilfrid Laurier University to offer *Reaching Out*, an eight-week program designed to help lay community leaders to develop an effective voice in municipal and regional government and advocate for local-level policy change (Waterloo Region Community Health Department, 2001; Schumilas, 2006).

Within RoWPH, the HDPED also worked to ensure the equitable delivery of all health unit programs and the removal of barriers to access. Beginning in 2002, the Division led a formal review process to assess each program’s compliance with the Equal Access Standard of the *Mandatory Health Programs and Services Guidelines* (Ontario Ministry of Health, 1997). This review led to the modification of RoWPH programs and services to improve access for all

community members (Waterloo Region Community Health Department, 2001; Schumilas, 2006).

Over time, the research, planning and evaluation capacity within the HDPED enabled it to play a key advisory role in shaping Region of Waterloo policies addressing the SDH. In 2002, Division staff focused on the development of sustainable food systems as a broad policy priority. As an initial step, the HDPED helped to initiate the incorporation of an autonomous food policy organization. The resulting entity, *Foodlink Waterloo Region*, continues to function as an independent organization promoting a local, sustainable food system (Schumilas, 2006, 2015). Collaborating with local community partners, the Division completed several inter-related research studies to gain a better understanding of the local food system and to provide community-level food system advocates with required data and information. This work culminated in the development of *A Healthy Community Food System Plan for Waterloo Region*, which was endorsed by Region's Community Services Committee in 2007 (Miedema and Pigott, 2007).

Beginning in 2004, HDPED staff, in concert with an inter-disciplinary team from across the Region of Waterloo, conducted a series of studies to guide the Region's Growth Management Strategy and the Regional Official Policies plan. These studies addressed a range of issues with the potential to be affected by population growth and demographic changes. One study, a comparative examination of the health of Waterloo Region residents living in six neighbourhoods characterized by differing urban design features, examined the relationship between health indicators (e.g., physical activity patterns) with key design elements including density, public transit and mixed use zoning (Schumilas, 2006). A subsequent study, *Urbanization and Health in Waterloo Region*, used region-level data collected in partnership

with Statistics Canada to examine the impact of community size and urban density on key variables including community connectedness, use of public transportation, physical and mental health, commuting patterns and access to amenities (Seskar-Hencic, 2008).

iii) Analysis of RoWPH's Actions on the SDH by Key Components of Multiple Streams Theory

The Problem Stream: Indicators of SDH Deficits

As was noted previously, the activities of the HDPED coincided with a time of strong economic growth and relative prosperity in Waterloo Region. The 2005 median income of all census families in Waterloo Region (\$74,070) exceeded the Ontario average (\$69,156), as did the median income of lone parent families (Statistics Canada, 2006b). The proportion of Waterloo Region residents with low income (before tax) had been declining steadily from 14.3% in 1996 to 11.0% in 2001 to 10.2% in 2006 (Region of Waterloo Public Health, 2010).

However, these positive trends masked growing income insecurity among some of the more vulnerable populations of Waterloo Region. As part of its ongoing 'Hunger Count' study, the Food Bank of Waterloo Region maintains annual statistics on the number of emergency food hampers distributed to families in need. After a slight decrease between 2000 and 2001 (40,610 to 39,973), the number of food hampers distributed in Waterloo Region rose significantly to 62,349 by 2005 (Food Bank of Waterloo Region, 2016). This increase was, in part, attributed to stagnant wages for low-income earners and the aforementioned growth in part-time jobs and precarious employment: the percentage of Waterloo Region food bank users earning income rose from 23% in 2002 to 29% in 2004 (Food Bank of Waterloo Region, 2016).

The economic opportunities in Waterloo Region at the time of the case attracted a growing population of new Canadians. Between 2001 and 2006, the immigrant population of Waterloo Region rose by 13.6%, almost double the rate of growth among the non-immigrant population (Regional Municipality of Waterloo, 2011). However, barriers to employment resulted in alarming rates of poverty among new immigrants to the Region. In 2006, the proportion of new immigrants (i.e., having arrived in Canada between 1996 and 2001) living with low income (after tax) in Waterloo Region was 33.5%, more than four times the corresponding rate of all Region residents (Statistics Canada, 2006b). Given this stark disparity, it is not surprising that the HDPED identified the employment and employability of immigrants as one of its priority areas for action (Schumilas, 2006).

The Problem Stream: Community Awareness

Respondents indicated that, while general community awareness of the SDH was relatively low when the HDPED was created, awareness and interest among key community stakeholders was high, giving the Division a base for SDH-focused community engagement and intersectoral collaboration. These groups included, but were not restricted to, the two community health centres in the Region (Woolwich CHC and Kitchener Downtown CHC), the Social Planning Council of Kitchener-Waterloo and Opportunities 2000, an anti-poverty coalition active in the Region at the time of the case (Nolan, 2016; Seskar-Hcncic, 2015). The RoWPH MOH, who served in this role for most of the duration of the case, provided the following description of community awareness of the SDH: *“I would say that there were pockets of knowledge. It probably would relate to community health-type organizations....And so those small groups of like-minded individuals along with us really understood and talked about those concepts a lot.”*

Respondents felt that, over time, the information sharing, community engagement and capacity building activities of the HDPED were effective in raising community awareness of the SDH. The MOH noted that this awareness building process *“took quite a bit of time with repeated dialogue with partners about the importance of the determinants of health and repeated production of reports and health impact assessment studies where we repeatedly called attention to the determinants of health. I would say by the end of 2009, the social determinants of health was a broadly used, well understood term in this community, including outside of the health sector. In fact, it was quite remarkable”*.

In their efforts to build awareness of the SDH and support for its new SDH-focused Division, the RoWPH also benefited from a Regional culture grounded in the altruistic values of its original Mennonite settlers. Although they did not explicitly frame their work in SDH terms, community organizations like Lutherwood and the Mennonite Central Relief Committee had established track records of providing vulnerable community residents with access to food, housing and employment opportunities (Nolan, 2016; Seskar-Hencic, 2015). The MOH offered the following explanation of how the prevailing norms of the community enabled the creation and sustainability of the HDPED:

“I don’t know - I’ve tried to figure out what it is about Waterloo Region, but I think there is something to this Mennonite heritage as well. A very definite concern and a number of agencies that have really strong beliefs in collective impact....you know, working together, helping others. So I think it [The HDPED] found a home in terms of the philosophy of a lot of the partners in this community even though they wouldn’t see themselves as ‘deliverers’ of the determinants of health.”

The Problem Stream: Focusing Events and Feedback

Respondents did not cite any single **focusing event** that led to the creation of the HDPED. Nor does it appear that community **feedback** about the lack of health unit action on the SDH prompted the organizational re-structuring. Although primary documentation pointed to the need for health unit re-organization in the wake of the *Healthy Babies/Healthy Children* program as a contributing factor to the HDPED's formation (Waterloo Region Community Health Department, 2001), respondents described this development in the broader context of a need to re-consider health unit priorities in light of emerging evidence about the SDH. The former Planning and Evaluation Manager of the HDPED summarized the myriad of questions faced by RoWPH during this time:

"I think public health was entering a time of renewal when the traditional concepts of 'what works' were beginning to be challenged at a number of levels....like are we actually making the difference we want to make in terms of achieving public health goals?...do we have the people and the skills to address the root causes of ill health?...are our staff trained to use new approaches and models in addressing these root causes? And then from an organizational perspective is there an appetite to pursue this type of agenda?"

The MOH concurred that the creation of the HDPED was not linked to any single focusing event or feedback about identified SDH deficits in the community. Rather, she attributed it to *"the philosophical understanding and belief that work on the determinants of health was really the main way to impact health....so it was kind of from a philosophical view of trying to re-orient the work and tackle issues from a different perspective. It wasn't out of a specific health deficit per se."*

Characteristics of Policy Entrepreneurs

RoWPH underwent a change in leadership in 2000 when the MOH responsible for the creation of the HDPED left the Region to assume the position of MOH at another health unit. The new MOH and the recently appointed Director of the HDPED wanted to ensure that the Division, which was still in its formative stages, benefitted from the advice and support of someone with experience in SDH-focused planning and community engagement. As a result, Dr. Trevor Hancock, an internationally renowned expert in health promotion, was hired as a consultant MOH to guide the development of the HDPED's structure and its initial workplan (Schumilas, 2015). It was felt that Dr. Hancock's background and credentials accorded him a **claim to a hearing** that would expedite the acceptance of the Division among Regional politicians and key community stakeholders. As one of the respondents involved in this transition process noted *"the same words coming from Trevor would mean more than the same words coming from me."*

There is little evidence -- either in the primary documentation or key informant interview transcripts -- that significant degrees of **political connectedness**, **negotiating skills** or **persistence**, the other key attributes of policy entrepreneurs identified in multiple streams theory (Kingdon, 2011), were required to obtain Region of Waterloo approval for the creation of the HDPED. As the ensuing section reveals, an opportune combination of timing and circumstances within the political stream enabled RoWPH to proceed with its SDH-focused re-organization.

The Political Stream

RoWPH differs from the other four local cases in the nature of its governance structure. Unlike the other four health units, which are governed by autonomous boards of health, RoWPH is one of seven Ontario health units operating under the administration of a regional government (Association of Local Public Health Agencies, 2015). In practice, this meant that RoWPH was accountable to Community Services Committee, one of the standing committees of the Regional Council.

This governance structure was viewed as a key enabler for the creation of the HDPED. Specifically, respondents felt that the alignment of the Regional government mandate with more upstream SDH issues, such as housing, transportation, the built environment and social assistance, made Regional decision makers more predisposed to understanding the rationale for the Division. In describing RoWPH's relationship with the Waterloo Region Council at the time of the case, the MOH noted that:

“We had a fair bit of stability in Regional Council who had equal interest in human services as well as infrastructure. So they cared about bridges and roads, but they also cared about social services and public health...because public health was at a senior level of government, they were predisposed to thinking about bigger issues.”

The HDPED utilized Regional Council as a venue for introducing reports covering a wide range of SDH issues. In describing this process, the MOH notes how this information sharing achieved dual objectives of raising public awareness and educating decision makers: *“all of the reports we produced around the economy or food systems or the built environment or whatever the issue was...we were able to use Council as a forum to launch those reports to get some attention but also to educate Council. And I truly think they believed in what we were saying.”*

In describing the political factors affecting the launch of the Division, the MOH also pointed to a previous decision of Regional Council that made it easier to build the case for a SDH-focused structure within the health unit. In the early 1990s, concerns about rising crime rates in Canada prompted the House of Commons Standing Committee on Justice to issue a report on crime prevention. The Region of Waterloo took an active interest in this work, submitting a response to the Standing Committee contending that “*our collective response to crime must shift to focus on the underlying social and economic factors associated with criminal behaviour.*” (Waterloo Region Crime Prevention Council, 2016). In 1995, two years after the federal standing committee had issued its final report, the Region of Waterloo acted on its values by creating and providing core funding to the Community Safety and Crime Prevention Council (now known as the Waterloo Region Crime Prevention Council), a community-based organization encouraging crime prevention through intersectoral collaboration and a focus on the ‘root’ causes of criminal activity (Waterloo Region Crime Prevention Council, 2016). A Council that had supported what, in many respects, was akin to an SDH-focused approach to crime prevention proved to be a receptive audience to the SDH-focused approach to public health that was presented to them several years later (Nolan, 2016).

RoWPH also benefitted from fortuitous timing in securing the human resources to staff the newly created Division. As was noted previously, the HDPED had 20 staff positions (Waterloo Region Community Health Department, 2001). But none of these were new positions requiring Council approval; rather, they were vacant FTE positions that had been set aside by the MOH for the Division. Had the HDPED been launched at a time closer to the Regional budget cycle, the positions may well have been ‘circled’ and RoWPH would have had to justify their

existence. But since the FTEs had been approved in advance of the budget cycle, they were not questioned and the Division was able to proceed with staffing (Schumilas, 2015).

Unlike some of the local cases assessed in this study (e.g., Peterborough City County Health Unit), a relatively favourable political climate was not conducive to direct advocacy on the SDH by health unit staff. Limitations on the extent to which HDPED staff could engage in advocacy for policy change was noted as a key ‘challenge’, both at the time of the Division’s creation and subsequently (Waterloo Region Community Health Department, 2001; Schumilas, 2006). A 2006 report on the HDPED observed that *“interest in policy advocacy seems to manifest itself in a staff group with a strong commitment to egalitarian practice and empowerment. This same group of staff can feel restricted and frustrated by the political and sometimes cautious nature of systemic change work within a governmental organization.”* (Schumilas, 2006 p. 183).

Rather than engage in direct advocacy, the HDPED made an early decision to focus on building the advocacy capacity of community change agents (Waterloo Region Community Health Department, 2001). Advocacy was a key area of focus in the ‘Reaching In’ workshops the Division conducted for community lay leaders.

In practice, this support extended to the provision of data and information that strengthened the case of community groups focused on specific SDH issues. Respondents felt that this approach met the dual objectives of strengthening the efforts of community change agents, who were not confined by bureaucratic restrictions on advocacy, while raising awareness of the HDPED and promoting positive relations between the Division and the community. The former Director of the HDPED provided an illustrative example of how a Division study on rural

health in Waterloo Region served as a catalyst for awareness raising and advocacy efforts of concerned community groups:

“By and large community groups were on our side....they were our advocates. And we turned to them as much as they turned to us. When a new report on rural health comes out where you really want to highlight the plight of small farmers in Waterloo Region - the stress, the suicide, like wow, how come nobody’s looking at this?... We had a healthy community group in Wilmont Township and they were just all over it. ‘We’re pleased to take this report. Help us frame the press release the response. Help us frame the community meeting where we come together to look at the results’I felt it to be very mutual.”

Rather than wait for requests for support, the HDPED was proactive in seeking out community groups focused on SDH-related policy change. The Division’s former Manager of Planning and Evaluation noted that *“What we did was a deliberate reaching out to organizations that we believed needed support and needed to get their voice heard. But to do that out of a government organization is not a typical thing to do.”*

The Policy Stream

As the first Ontario health unit with a Division dedicated to action on the determinants of health, RoWPH did not have the benefit of advice from other health units with prior experience in setting up SDH-focused structures. As a result, the HDPED focused heavily on establishing the **clarity of directives** required for effective action and building internal **capacity** during its first two years of operation.

There was some concern that the time taken to establish SDH-focused priorities and build the internal capacity to address them came at the expense of engagement with key community stakeholders. A two year progress report on the HDPED noted that *“our regret is that, in this busy period - we did not spend as much time as would be ideal in partnership building outside*

of the department. For a period, we had to assume that our partners are out there -watching and waiting - while we turn inward. We think our history of community work and the trust we have built over the years will carry us through what, due to time pressures and limited resources, has to be a non-consultative phase.” (Waterloo Region Community Health Department, 2001, p. 4).

There was also some concern about how community organizations, many of which had a long and positive history of collaboration with RoWPH, would respond to a new entity with a broad and seemingly nebulous mandate. Specifically, there was a risk that the HDPED could be perceived as a superficial re-packaging of traditional public health initiatives. The former Director of the HDPED describes an early planning meeting where a discussion of these challenges reinforced the view that the Division had to offer something that was both innovative and of value to community partners:

“We had been engaged with community organizations on many of the same issues. But we weren’t calling them ‘determinants of health’. And so I remember one of the discussions was are we just calling what we’re doing something different? And that would have been a real letdown. ‘Cause I think there was this hope that....we had a new something. We either had new knowledge or new tools or new resources. We had something that could help address the problems groups had been working on for decades.”

As was the case with the other local health units in this study, RoWPH struggled to identify SDH priorities within the **accountability** requirements set by the 1997 MHPSG, the provincial directives specifying health unit activities at the time of the case (Ontario Ministry of Health, 1997). After exploring different directions, the HDPED decided to focus its resources on three broad policy areas: i) sustainability, with a focus on local food systems, ii) equity with a focus on employment and employability of immigrants, and iii) livability, with a focus on land use planning and chronic disease prevention. These priorities were chosen because their links to the MHPSG were relatively straightforward. For example, walkable communities and accessible

food had been well established as requisite social and environmental conditions for chronic disease prevention (Schumilas, 2006).

Over time, food became a natural focus for the HDPED. This was due to the inclusion of nutrition/healthy eating as part of the mandate of public health units as well as the relationships between food access, food safety and other SDH. The former Director of the HDPED observed that *“food became very special to us because early on we figured out that this was an unquestioned thing for public health to be working on. And it’s just semantics really because you can be working on food, but also working on poverty and the environment....so we did a lot of work there.”*

The capacities required for the successful operation of the HDPED were identified through a series of mapping exercises using the *Ottawa Charter* and the *Indicators That Count* documents (Seskar-Hencic, 2015; Schumilas, 2015). The existence of 18 approved vacant FTE positions within RoWPH provided the Director of the Division with the advantage of being able to recruit individuals with the desired skill sets instead of relying on existing human resources: *“We could do a mapping that said what skills do we have? What skills do we want to get? And I could go get them. I didn’t have to massage what we already had.”*

The breadth and complexity of the HDPED’s mandate necessitated the recruitment of individuals with qualifications outside the realm of traditional public health practice. The Director recalls that the HDPED hired *“....a number of people who came from community psychology. We really found that community development skill set there. We had some people from land use planning who had a real GIS kind of skill set. We were looking for that.”* The diversity of paradigms, work cultures and frameworks within the HDPED challenged existing

RoWPH staff to expand their own knowledge of SDH-related concepts and strategies in order to engage in effective community outreach and advocacy support (Schumilas, 2006).

Table 5: RoWPH Case Summary and Degree of Convergence Between Streams

Component of Multiple Streams Theory	Description
The problem stream	<ul style="list-style-type: none"> • emerging pockets of SDH deficits (poverty, food security, unemployment) among marginalized groups during period of strong economic growth within Waterloo Region. • general community awareness of SDH was low, but awareness/support for SDH actions high among key community service providers, many of which had a history of collaboration with RoWPH. • traditional community culture placed strong emphasis on helping those in need. • creation of Health Determinants Planning and Evaluation Division within RoWPH not prompted by any focusing event; rather arose from need to re-consider public health practice in light of emerging evidence about ‘upstream’ factors contributing to population health.
Characteristics of policy entrepreneurs	<ul style="list-style-type: none"> • departure of RoWPH MOH shortly after the creation of the Division led to engagement of internationally recognized health promotion expert with recognized credibility/authority (claim to a hearing) who assisted RoWPH in establishing Division structure and priorities. • little evidence of other key attributes of policy entrepreneurs (persistence, political connectedness, negotiating skills) as favourable confluence of events enabled timely establishment of the Division within RoWPH.
The politics stream	<ul style="list-style-type: none"> • RoWPH differs from other local cases, as it is accountable to a committee of Waterloo Region rather than an autonomous BOH. However, this was regarded as an advantage due to alignment of regional government mandate with key SDH issues (e.g., housing, urban planning, transportation). • antecedent event, Waterloo Region’s approval of a Community Safety and Crime Prevention Council, focused on the social and economic causes of criminal behaviour in 1995, may have made the Region more supportive of a Determinants of Health Division within RoWPH. • favourable timing (i.e., the existence of approved staff positions between budget cycles) enabled RoWPH to proceed with staffing the Division. • political considerations appear to have limited direct advocacy by the Division; as an alternative, the Division focused on building the advocacy capacity of local organizations and service providers with SDH-related mandates.
The policy stream	<ul style="list-style-type: none"> • Division activities focused heavily on establishing clarity of directives for SDH-focused actions and building both internal and external capacity for SDH initiatives. • broad policy areas informed by mapping exercises and priorities of 1997 <i>Mandatory Health Programs and Services Guidelines</i>. • breadth and complexity of Division’s mandate led to recruitment of individuals with skills outside traditional domains of public health practice.
Evidence of stream convergence (coupling)	<ul style="list-style-type: none"> • problem stream aligned with favourable aspects of political stream, though possibly not to the point where a partial ‘coupling’ occurred. • alignment of problem and political streams enabled fulsome policy solutions to emerge over time. • some indication of interdependence: factors in political stream prescribed nature/scope of policy stream options

7.4 Huron County Health Unit (HCHU)

i) Key Demographics at Time of Case

Located in southwestern Ontario, north of the City of London and west of the ‘golden horseshoe’ encompassing Hamilton and the Greater Toronto area, Huron County is approximately 100 km long from north to south and 50 km wide from east to west. With only one incorporated town (Goderich) and a population density of 17.7 persons per square kilometre, Huron County is one of the most rural areas of Ontario (Huron County Health Unit, 2009; Huron Business Development Corporation, 2010). The population of Huron County during the time of the case remained relatively stable, decreasing by less than one percent from 59,701 in 2001 to 59,325 in 2006 (Statistics Canada, 2006c).

The rural nature of Huron County is reflected in the composition of its economy. A 2008 review of Huron County businesses by sector found that agriculture and mining (the world’s largest salt mine operates in Goderich) comprised 35% of all businesses, followed by personal, business and other services (21%), and retail and wholesale trade (13%). Compared to other regions of Ontario, the economic profile of Huron County is notable for its high proportion of farms and relative lack of retail, manufacturing and service sector businesses (Huron Business Development Corporation, 2010). Although agriculture was the mainstay of Huron County’s economy at the time of the case, the number of operating farms in the County declined by 5% (from 2,880 to 2,738) between 2001 and 2006 as a result of operational consolidation in the agri-foods sector (Huron Business Development Corporation, 2010).

Huron also differed from provincial trends in the age structure of its population at the time of the case. In 2006, Huron County's population was proportionately older, with a median age of 42.3 years compared to the provincial median of 39 years. The percentage of Huron County residents of working age (15-64 years) was lower than the corresponding province wide figure (63.5% vs. 68.3%), and Huron County had a significantly higher proportion of seniors (17.9% vs. 13.6%) compared to the province (Statistics Canada, 2006c). This divergence in age patterns was attributed to a high out-migration of youth (<24 years) from Huron County during the time of the case (Huron Business Development Corporation, 2010).

A cursory glance of key indicators during the time of the case indicates that the socio-economic status of Huron County was relatively positive. Although the 2005 median income of Huron County residents was significantly lower than the provincial average (\$62,446 vs. \$69,156), this was primarily attributable to only half as many Huron County households earning over \$100,000 per year (Statistics Canada, 2006c, Huron County Health Unit, 2009). The 2005 unemployment rate in Huron County was lower than the provincial average (4.4% vs. 6.4%), and the percentage of Huron County residents living in low income after tax (4.8%) was significantly lower than the corresponding provincial figure of 11.1% (Statistics Canada, 2006c). However, these County-wide figures concealed large pockets of poverty exacerbated by deficits common to rural communities, including seasonal employment, a dearth of community and child care services and transportation barriers (Huron County Health Unit, 2009).

ii) Chronology of Events

In 2004, HCHU initiated an organizational re-design of the health unit to update its service planning, program implementation and evaluation to better reflect new and emerging

community needs and innovations in public health practice. This re-design resulted in a more multi-disciplinary approach to service delivery as well as the incorporation of the determinants of health into HCHU planning and priority setting (HCHU, 2006, Henning, 2016).

Following a series of staff retreats, the new structure was launched in 2005. A multi-year strategic plan based on the new structure identified a “determinants of health framework” as a key service delivery principle. Specifically, HCHU recognized *“that health is determined by the complex interactions between individual characteristics, social and economic factors and physical environments. Strategies to improve population health must address the entire range of factors that determine health.”* (HCHU, 2006, p. 2).

To make this principle a working reality, the determinants of health were embedded into a prioritization tool developed by the health unit. This tool (see Appendix E) required HCHU staff to ascertain if: a) identified community health needs were determinants of health, b) how HCHU can make prescriptive programs more accessible to those in the community at greatest risk and c) if program-related outcomes impacted determinants of health. For the purposes of program planning/implementation and resource prioritization, HCHU adopted the twelve determinants of health identified by the Public Health Agency of Canada (HCHU 2005).

The new HCHU organizational structure divided staff into one of four ‘quads’: supporting healthy communities, building community capacity, protecting the environment and strengthening families (Henning and Nelligan, 2005). Rather than creating a designated internal structure for SDH action, HCHU made a conscious decision to situate the SDH as cross-cutting priority across all quads. This was done to ensure an organic, multi-disciplinary response to SDH

issues and to build collective ‘surge capacity’ during times of emergencies (Henning and Nelligan, 2005; Nelligan, 2016).

HCHU also worked to build the internal capacity to implement its new structure. A series of all-staff meetings in 2005 provided training on the determinants of health and their application in HCHU planning and priority setting (HCHU, 2006). Job descriptions for new positions were written to include knowledge of the SDH and health equity concepts and strategies as requisite skills. For example, a job description for a Community Developer position within HCHU included “*experience working with communities addressing health and social inequities and basic health prerequisites*” as a minimum qualification and working with other HCHU staff and “*advocacy for basic health prerequisites*” as a key position responsibility.

HCHU’s efforts to proactively address the SDH culminated in the release of a comprehensive community health status report that highlighted the key SDH indicators and deficits in Huron County (HCHU, 2009). The MOH and Director of the HCHU intended to use this report and the new organizational structure as the basis for a series of community consultations with the goal of fostering HCHU-community collaborations for joint action on SDH priorities. However, these efforts were blocked by an incoming County Warden who did not share HCHU’s beliefs in the importance of SDH-focused public health practice. This political opposition ultimately led to the resignation of the HCHU MOH and Director in 2008 and the subsequent termination of the organizational structure (Henning, 2016; Nelligan, 2016).

iii) Analysis of HCHU's Actions on the SDH by Key Components of Multiple Streams Theory

The Problem Stream: Indicators of SDH Deficits

As was noted previously, the relatively positive indicators of socio-economic status among Huron County residents masked deeper problems. Although the unemployment rate in Huron County at the time of case remained below the provincial average, it had been rising since 2001 (Statistics Canada, 2001c, 2006c). This increase was, in part, attributable to the loss of job opportunities in the agricultural sector -- the mainstay of Huron County's economy -- resulting from shrinking commodity prices and farm consolidation (Huron Business Development Corporation, 2010). In addition, Huron County consistently underwent a seasonal increase in unemployment due to its strong reliance on harvesting agricultural crops (Huron County Health Unit, 2004).

There is considerable evidence that Huron County residents living in low income experienced barriers to accessing the pre-requisites for good health, such as food and shelter. In 2006, there were only 627 social housing units in all of Huron County, with 251 households on the waiting list for rent-geared-to-income units (Huron County Health Unit, 2009). Although Canadian Community Health Survey data indicated that only 4% of Huron County households reported food insecurity, this figure is incongruent with the high attendance at the eight food banks in Huron County, which were visited by an estimated 6,500 to 7,100 families or individuals in 2005 (Huron County Health Unit, 2009). Given that the entire population of Huron County was slightly under 60,000 at that time, the CCHS data may have under-estimated the true

proportion of Huron County residents experiencing food insecurity (Huron County Health Unit, 2009).

To better understand the barriers to food access faced by low income families, HCHU conducted a series of focus groups (N=45) in 2000. Participants felt that social assistance cutbacks and unexpected expenditures left them with insufficient money to spend on food after paying for rent and other essential costs. Participants also identified barriers characteristic of rural areas. These included: the high costs of groceries in small towns, lack of affordable transportation to shop for food in larger regional centres, and stigma affecting participants' comfort with accessing food banks in 'small town' environments (Huron County Health Unit 2002).

The Problem Stream: Community Awareness

Respondents agreed that awareness of the SDH among Huron County residents was fairly low, with the possible exception of local social service agencies. When asked about community perceptions of the SDH at the time when HCHU began re-structuring to more actively address them, the then-Health Unit Director observed that *"I guess there probably must have been someone somewhere who understood...I think there would have been groups who would have understood some of the concepts if you spoke about them."* The MOH at the time of the case concurred with this viewpoint, noting that the demographic feature of Huron - a dispersed population over a rural area - hindered collective action on the SDH:

"There were pockets of knowledge. Huron is such a rural area. There's not any community larger than eight thousand people. So it's pretty disparate. Certainly nobody was advocating for them [the SDH]. It wasn't something you heard about."

Not surprisingly, given its rural nature, food security was the one SDH that resonated with Huron County residents. Over the duration of the case, HCHU launched a *Field to Table* produce distribution program that subsequently expanded in scope to involve more community partners. The Director described how the program strengthened community efforts to address food insecurity and addressed the SDH at multiple levels:

“Field to Table. That was amazing....that was a fabulous program...it grew to where people with serious mental health issues were volunteering in the program, so they were engaged in the community. The local grocery stores were involved. They were selling more of the products. And it got to the point where the farmers were growing produce for our good food box....that was a fabulous example of how a whole community got on board and benefitted from it.”

The former HCHU MOH described how the longer-term impacts of the Field to Table program extended beyond food insecurity while engaging an ever-broadening segment of the community: *“..they had a community garden, community kitchens. The farmers got involved. And the volunteers - actually a lot of them went on to get employment. They had been in trouble and not able to get employment because they didn’t have resumes. And so the program helped - even the people involved in delivering the program were benefitting.”*

The lack of community awareness of the SDH (and the lack of capacity for SDH-focused collective action) was offset by the support of a powerful local political champion who ensured that HCHU had the necessary support to proceed with its SDH-focused organizational restructuring. Over the duration of the case, this individual served as Chair of the HCHU Board of Health, Mayor of Goderich, and the Warden of Huron County. In describing the factors that led to his support for HCHU’s SDH-focused actions, he demonstrated an awareness of the health impacts of SDH deficits in Huron County and the need for remedial action:

“I think there were a lot of people who were on the poverty line or under it. And I think, having knowledge of that, it seemed to be the thing to do - to try to upgrade those in need. Because usually economic development relates to health: the better people do, the better their health tends to be. And certainly I was aware that there needed to be some action taken.....too many people needed a hand up and some help. We needed some programs that reached them.”

The Problem Stream: Focusing Events and Feedback

Unlike some of the local health unit cases described in this study (e.g., Sudbury, Leeds-Grenville-Lanark), there does not appear to be a pivotal **focusing event** that prompted HCHU to be more proactive in addressing the SDH. Nor was there evidence of community **feedback** about the limitations of health unit services addressing the SDH, as was the case with Peterborough City-County Health Unit. Rather, the SDH-focused actions of HCHU appear to have been the product of two like-minded senior administrators, the MOH and the Health Unit Director, who shared a similar vision of public health practice. When recollecting the discussions that led to the organizational re-structuring the Director noted that *“We are like-minded. So we were able to support each other through trying to make this work.....So I think the fact that we were both there at the same time, with the same thought, certainly helped us.”*

Characteristics of Policy Entrepreneurs

There was some evidence of **claim to a hearing**, the recognized credibility of the MOH and Health Unit Director as advocates for SDH-focused practice, on the part of HCHU’s key political ally who chaired the HCHU Board of Health. Over the course of the interview, he expressed confidence in their ability to shift HCHU towards a more SDH-focused scope of services:

“I had served on hospital boards and stuff like that, so I’m fairly familiar with health. But still I’m just a lay person....Certainly having faith in our Medical Officer of Health and Director. As an elected official you really need to put your faith in your administration because it’s difficult to ‘see all/know all’. And when they explained what this restructuring to focus on the determinants of health was and the desired outcomes, it was, for me, a no brainer to support it.”

In describing the efforts of the MOH and Director to build BOH support for the SDH-focused re-structuring, the former BOH Chair also noted how they displayed the attribute of **persistence**, the investment of time and resources in multiple fora (i.e., the Board of Health and Huron County Council) needed to advance a policy agenda (Kingdon, 2011). The BOH Chair felt that these opportunities for dialogue were instrumental in building the requisite political support.

“What I liked is that they did their presentations to the full Board and explained things well. They tried to lay out what the outcomes would be if we chose a certain route. And I think there was always good discussion amongst the Board....At the same time, they would come every so often to the total governance Council, which is all of Huron County. And I think that played a big part - just communications. You know I’ve been involved almost thirty years in political life and good communications is the key to everything. And I think they had a very clear communications strategy. They touched enough bases so people understood where they were heading.”

The Politics Stream

Respondents indicated that the response to HCHU’s SDH-focused organizational re-structuring among political decision makers was initially favourable. The BOH Chair and County Warden during this time recalls that he *“really didn’t see where there was any major attempt at interference from the Board or the balance of Council...I don’t recall anybody slamming the table and saying ‘we don’t think this is the right way to go,’”*

The HCHU MOH who oversaw the restructuring noted that although the BOH was *“not necessarily on board to begin with,”* they became more supportive over time: *“as the process*

unfolded, they did provide support and actually advocated for us in some settings....they advocated for our model.” The HCHU Director concurred, observing that, over time, the HCHU BOH *“as a whole became very, very interested and wanted to know more about it [the SDH-focused re-structuring process]. So that stood us in good stead.”*

The ability of the HCHU MOH and Director to address potential concerns about **cost**, a key barrier to the adoption of SDH-focused actions (Lefebvre et al., 2006), was identified as a key factor that secured political support at both the BOH and County Council level. The BOH Chair and County Warden at that time recalled that:

“Well, I think in a rural area it’s always money. Is it going to cost more? I think that still is the main question among elected officials. I think when it was pretty well assured that it [the SDH-focused re-organization of HCHU] could be done within the budget they already had it was supported. I can’t remember anything that put up road blocks.”

Strong support from the HCHU BOH was evident in 2006 when the health unit underwent a review and accreditation process directed by the Ontario Council on Community Health Accreditation (OCCHA). The HCHU Director described the positive, unsolicited BOH feedback emanating from the review process: *“I forget the name of the person from the Ministry - she came around to do the review and met with the Board. She came out and said, ‘I can’t believe it. I can’t get them to say anything critical about you. They thought you were fabulous.”*

In addition to a supportive BOH, HCHU benefitted from a key provincial-level champion, the then-Chief MOH for the province of Ontario, Dr. Sheela Basrur. The HCHU Director recalled a positive, encouraging response when Dr. Basrur attended a presentation on HCHU’s SDH-focused re-structuring:

“I think another enabler was that our Chief Medical Officer of Health loved what we were doing...She came in and groups of staff presented the work we were doing. And she was super-keen and wanted to know more about it... we knew that she loved what we were doing.”

Unfortunately, the positive confluence of local and provincial support for HCHU’s SDH-focused activities proved to be short-lived. In December 2006, Dr. Sheela Basrur resigned her position as CMOH due to what proved to be a terminal illness. At the county level, municipal elections held during the previous month yielded a slate of more conservative elected officials who were less favourably disposed to arguments for reducing health inequities by addressing the SDH. The now precarious political climate took a marked turn for the worse the following year when HCHU’s key political champion, who served as the BOH Chair for most of the duration of the case, stepped down as County Warden. The culmination of these events is summarized in a short article published in the *Seaforth-Huron Expositor*, a community newspaper serving Huron County:

Medical Officer of health resigns after months of tension between health unit and county administration

Wednesday August 20, 2008

“Huron County’s medical officer of health (MOH) has resigned following months of tension between the Huron County Health Unit and county administration..... ‘My understanding is she’s just looking for change, just looking for a break,’ said Huron County Warden _____. ‘It’s a very demanding job, there’s no two ways about it....There’s a lot of liability involved.....Current Board of Health Chair _____ said he communicated with Dr. _____ prior to her resignation and was not surprised by her decision. ‘Unfortunately, there’s been a breakdown in the relationship between the county and the Health Unit and that’s well known, he said. ‘That relationship has eroded over time.’” (Forrest, 2008, p. 1).

Over seven years after the fact, the HCHU MOH and Director provided their recollection of the events that led to the resignation of the MOH. The HCHU Director described the discernable decline in political support and a new emphasis on fiscal accountability:

“A new Warden who called himself a fiscal Conservative thought we were just doing too much....So that was all kind of happening in the background. And there was this whole thing about money - that the public health unit money was theirs and we were spending it on public health....So there was all this change to the political environment where the previous Councillors thought we were doing the greatest things. Our previous Warden thought we were putting Huron County on the map.”

The HCHU MOH recalls the moment she reached a “tipping point” when she realized that the new political realities in Huron County would not enable her to remain and implement her vision of SDH-focused public health practice: *“So I remember thinking I wouldn’t have to work through another year of Council. That it was my last Council. So yes, he [the new Warden] was there. Absolutely.”*

Over the course of their interviews for this case study, the former HCHU MOH and Director pointed to two external factors that, in their opinion, hindered their ability to sustain the Health Unit’s re-organization in the face of diminished political support. The first factor concerns the level of community engagement in the SDH. Unlike some of the other local health units in this study, such as Sudbury, Peterborough and Waterloo Region, HCHU did not operate in a community with strong grassroots support for action on the SDH. As a result, there was minimal awareness of, or support for, HCHU’s SDH-focused restructuring by community groups. With the benefit of hindsight, the MOH felt that greater emphasis might have been placed on building community support for SDH-focused activities. However, the rural, dispersed nature of Huron County might have prohibited the achievement of this objective:

“We didn’t have strong community partners. I don’t know who they would have been...If we could have waved a magic wand, that might have been what I wanted to do: engage community partners. And again, in a disparate health unit with so many communities it would have been difficult to find them. That’s the one thing I can think of that was tough for us.”

The second external factor that may have limited HCHU’s ability to sustain its SDH-focused re-organization concerns an aspect of administrative governance that caused considerable discord among Ontario health units at the time of the case. Prior to 1998, the *Health Promotion and Protection Act* had explicit provisions that the MOH serve as CEO of the health unit. As part of the downloading of public health service costs to municipalities (See Section 6 for additional information), these provisions were amended to give the MOH responsibility to the Board of Health for the management of public health programs and for providing direction to staff whose duties pertain to the delivery of public health programs (Capacity Review Committee, 2006). In a few health units, these amendments gave rise to ‘matrix’ or ‘shared leadership’ models where senior leadership was divided between a full time (non MOH) CEO and a full or part-time MOH. HCHU was one of the health units that adopted this model, as the Health Unit Director also served as the HCHU CEO.

The rise of shared leadership models among some health units was a source of contention within the public health sector, with proponents pointing to key advantages (e.g., a shortage of MOHs, not all MOHs are explicitly trained to assume the role of CEO), while opponents expressed concern about the apparent lack of alignment between legislative responsibility and executive authority, the potential marginalization of non-MOH CEOs and potential interference with the MOH’s ability to report directly to a BOH. The divergence in opinion was so pronounced that a provincial committee struck to review the structure and capacity of Ontario’s

public health system was unable to reach consensus on whether the role of health unit CEO should be assumed by non-MOHs (Capacity Review Committee, 2006).

As the senior administrators of a health unit with a shared leadership model, the HCHU MOH and CEO reported feeling marginalized by other health units where the MOH served as the CEO. Specifically, the MOH felt that perceptions of HCHU as a “*rogue health unit*” inhibited both the sharing of SDH-focused practices with other health units as well as the support from her peers for HCHU’s SDH-focused re-organization efforts:

“To be frank, I think another thing that made it hard for us was the lack of support we got from our peers in public health.....because we had a joint leadership model, we were considered kind of a rogue health unit. So if we went looking for help around the re-structuring or anything, I think we had a little more difficulty. And there was less sharing with my colleagues, the other Medical Officers of Health, because I was considered an outlier within public health.”

The Policy Stream

The administrative and geographic characteristics of HCHU, a small health unit serving a primarily rural county, were identified as both an asset and a liability for its SDH-focused restructuring. On the one hand, HCHU’s small size enabled a more rapid integration of the SDH into its scope of practice than might have been the case in a larger health unit with a more complex organizational structure. As the Health Unit Director notes, “*I think one of the enablers for us actually was being a small health unit. I think what we did could have been done anywhere, but it would have been a bit mind-boggling for a huge health unit.*”

Conversely, the rural nature of Huron County posed a barrier to the adoption of SDH-focused programs and policies, many of which had been initiated by public health authorities serving larger, urban areas. The Health Unit Director recalls meetings where the ‘urban-centric’

assumptions of her colleagues posed barriers to the sharing of best practices for addressing the SDH.

“We were a rural health unit. Rural health units don’t get a lot of attention, and the issues are so different. I can’t tell you how many times I sat on committees in Toronto and would say things like ‘we have no public transportation!’...We have no cities!”

A lack of understanding about the unique challenges of rural health units also extended to decision makers at the provincial level. The Health Unit Director describes one instance where HCHU’s inability to comply with provincial funding criteria, which were geared towards larger, more urban health units, led to the denial of funding for a comprehensive school health initiative: *“It was a really good proposal....They wanted the project to be centralized in one school. Transportation would have been an issue, but we got turned down because it was supposed to be in one school....but we just did what we did.”*

HCHU is unique among the local health units included in this study in that its efforts to establish **clarity of directives** for SDH-focused action and build staff **capacity** were premised explicitly on the principles of systems theory. Systems theory is based on the notion that the function of complex systems depends on interactions between heterogeneous elements that cannot be fully understood by examining these elements in isolation of one another (Jackson, 2003). Public health advocates have noted the potential utility of systems theory as a means of identifying leverage points for intervention on complex issues such as the SDH (Green, 2006; Mabry et al., 2010).

A 2005 overview of HCHU’s restructuring noted that the re-organization addressed two key premises of systems theory: 1) that issues (such as the SDH) are systemic and complex,

requiring multiple strategies, and 2) present institutions (HCHU) are organized in a fragmented way and are not sufficiently responsive or integrated to address complex issues (Henning and Nelligan, 2005). The Health Unit Director recalls the fragmented nature of HCHU's organizational chart prior to the onset of the restructuring process: *“our health unit teams were very much in their own silos. Small health unit, relatively small building. It was just amazing to see.”*

In an effort to dismantle the organizational ‘silos’ and create a more integrated organization with a greater level of capacity for SDH-focused actions, the Health Unit Director and MOH embarked upon a participatory planning process designed to illustrate the complexity of public health issues and the need for integrated responses. The Health Unit Director describes how one early planning exercise resulted in a breakthrough moment where HCHU staff appreciated the interconnectedness of the issues they addressed in their day-to-day practice:

“So we started off - I don't remember if we wrote scenarios or we had each team bring us scenarios...we had one person and this huge ball of yarn. We had one person who started off holding the ball, and then in the scenario there would be an opening...where another team's work would be relevant. So the ball would go over there. And by the end of it we had a spider web wrapped around people...almost wrapped around the room. And it was a really significant moment, I think...their awareness that the theory we were talking about wasn't just intellectual hoo-hah...it really helped them understand it.”

This system-focused planning process culminated in the integration of SDH across all branches of the re-organized health unit (i.e., the four ‘quads’) and the introduction of common planning and priority setting templates that incorporated the SDH as a key consideration. The HCHU MOH at the time of the case describes how this approach differed from that of other health units that chose to address the SDH by establishing designated structures (e.g., SDH committees or Divisions).

“Our whole structure was to integrate all of that [the SDH] into practice....they had to do their plans around it. They had to do everything around determinants of health....that was a difference I saw from most of the other models. A lot of them were working with mandates to address the social determinants. But I don’t remember anybody who actually used a model conceptually to determine how the people worked.”

In practice, the re-organization was seen as having achieved its goal of greater service integration and the increased **capacity** of health unit staff to provide a more coordinated response to SDH-related issues. The HCHU MOH describes a specific example involving the Healthy Babies/Healthy Children (HBHC) program and HCHU’s environmental health services.

“...the nurse would have been visiting and identified issues in the family. She would talk to the group she was in, which included some public health inspectors. And they would say, ‘well, there are certain issues with the housing and the water....and this is what we can do to address them.’ And so a lot of programs, because the teams were integrated and also focused on the social determinants of health, ended up addressing issues much more holistically.”

Table 6: HCHU Case Summary and Degree of Convergence Between Streams

Component of Multiple Streams Theory	Description
The problem stream	<ul style="list-style-type: none"> • evidence of SDH deficits around unemployment, poverty and food arising from seasonal nature of local economy heavily dependent on agriculture and consolidation of farms; also barriers to service access (e.g., lack of public transportation) characteristic of a highly rural area. • low community awareness of SDHs and their impact on health • no identifiable focusing event or community feedback precipitating HCHU’s SDH-focused restructuring
Characteristics of policy entrepreneurs	<ul style="list-style-type: none"> • recognized claim to a hearing, authority and credibility of HCHU MOH and Director to advocate for SDH-focused public health practice. • demonstrated persistence in making the case for SDH initiatives over time, both within HCHU BOH and Huron County Council.
The politics stream	<ul style="list-style-type: none"> • HCHU’s SDH-focused reorganization supported by key political champion who served as BOH Chair and County Warden • HCHU also had key provincial ally, the CMOH • changes in the political stream, the resignation of the CMOH due to illness and an incoming County Warden who did not support HCHU’s SDH initiatives, led to the termination of the new SDH-oriented structure • other possible factors contributing to demise of HCHU’s SDH-focused reorganization include: lack of engagement with potential community allies to build support, limited support from peer health units due to HCHU’s contentious administrative structure (i.e., the MOH did not serve as health unit CEO), and the failure of provincial funders to understand the unique needs of rural health units.
The policy stream	<ul style="list-style-type: none"> • elements of systems theory used to establish clarity of directives around SDH-related initiatives and build HCHU staff capacity for implementation. • re-organization viewed as having enabled more integrated approach to addressing SDH across scope of health unit services
Evidence of stream convergence (coupling)	<ul style="list-style-type: none"> • limited evidence of stream convergence; HCHU re-organization arose due to joint vision and commitment on the part of the key policy entrepreneurs: the MOH and Director • an initially favourable political stream enabled action, but changes in the stream over time, especially the loss of the key local level political champion (the BOH Chair and County Warden) forced the termination of the initiative.

7.5 Sudbury and District Health Unit (SDHU)

i) Key Demographics at Time of Case

Sudbury and District Health Unit (SDHU) serves Greater Sudbury and the District of Manitoulin. Greater Sudbury, more commonly referred to as Sudbury, is the largest city in northern Ontario and is governed by a single-tier municipality created in 2001 following the amalgamation of the City of Sudbury with surrounding regions and townships (Social Planning Council of Sudbury, 2009; Greater Sudbury, 2016). Manitoulin District, which comprises Manitoulin Island as well as a number of smaller islands surrounding it, includes two towns, eight townships and seven First Nations reserves (Federation of Northern Ontario municipalities, 2016). The population of the SDHU catchment area grew slightly (by 0.8%) over the time of case from 190,841 in 2001 to 192,391 in 2006 (Statistics Canada, 2006d). The catchment area includes a high percentage of Francophone residents, with over 25% identifying French as their first language (Statistics Canada, 2006d).

The economy of Greater Sudbury was dominated by forestry and nickel mining for much of the twentieth century (Wallace and Thomson, 1993). By the time of the case, however, the local economy had undergone an incremental process of diversification from resource extraction to technology, education, government, retail and health services (Greater Sudbury, 2016).

Sudbury has three post-secondary institutions - Laurentian University, Cambrian College, and Collège Boréal. Sudbury is also home to the Hôpital régional de Sudbury/Sudbury Regional Hospital and the Northeastern Ontario Regional Cancer Centre, which are the main providers of tertiary health services in northeastern Ontario. Following a period of land reclamation, which began in the late 1970s to redress decades of environmental degradation from nickel extraction

and processing, Sudbury also emerged as a tourist destination through attractions such as Science North, an interactive science education centre (McCracken, 2013; Greater Sudbury, 2016).

This economic transformation of Greater Sudbury is evident in the changing composition of its labour force over the last four decades. In 1971, the two major nickel mines in Sudbury, Inco (now Vale) and Falconbridge (now Glencore) employed over 25,000 people, one-fourth of the local workforce: by 2006, the percentage of the Greater Sudbury labour force engaged in resource extraction had shrunk to 8.1%, while the percentage of the workforce employed in service-based activities had grown to over 80 percent (Statistics Canada, 2006d; Greater Sudbury, 2016).

ii) **Chronology of Events**

SDHU's focus on the SDH commenced in 2000, with the arrival of a new MOH whose training and prior career experience had led her to become a committed advocate for a more upstream approach to addressing the root causes of ill health in communities. She focused on building local awareness of the SDH through a series of presentations to key community organizations, including the Rotary Club of Sudbury, the Social Planning Council of Sudbury and local businesses (SDHU, 2010). These presentations focused mainly on the relationship between community health status and poverty (Sutcliffe, 2015).

The MOH's early efforts to increase community awareness of the SDH coincided with the death of Kimberly Rogers, a Sudbury resident who passed away while serving a house arrest sentence for social assistance fraud in August 2001. This was cited as a key **focusing event** that strengthened SDHU's resolve to take action on the SDH and galvanized support among key

community groups for a more proactive response to the SDH on the part of the health unit (Canadian Public Health Association, 2014; Gasparini, 2016).

Beginning in 2003, a Determinants of Health Task Group organized within the health unit focused on building the capacity of SDHU staff to address the SDH. Over the next two years, a series of staff education events were held to increase internal knowledge and awareness of the health impacts of the SDH. The capacity of SDHU to address the SDH was strengthened in 2006 with the creation of a dedicated full-time managerial position responsible for overseeing health equity work (SDHU, 2010).

A key step towards the institutionalization of an SDH-focused approach within the health unit occurred in May 2005 when the SDHU Board of Health adopted a determinants of health position statement. The position statement (see Appendix F) committed the SDHU to a *“population health approach to improve the health of the entire population in its catchment area and to reduce health inequities among population groups”* The achievement of ‘health improvements’ was defined as the product of *“effective action on the broad range of factors and conditions that determine health.”* (SDHU, 2005, p. 1). Over the ensuing years, the Sudbury BOH passed a series of SDH-related motions addressing equity based planning, the reduction of child poverty, adequate nutrition for Ontario Works and Ontario Disability Support Program recipients and low wage earners, the National Child Benefit supplement, and a Greater Sudbury Community Strategy for Poverty Reduction developed in collaboration with the Social Planning Council of Sudbury (SDHU, 2009).

Over the duration of the case, the SDHU also played an active role in external opportunities to advocate for greater action on the SDH. In April 2002, the SDHU MOH made a

deputation in a public hearing of the *Romanow Commission on the Future of Health Care* in Canada held in Sudbury (SDHU, 2010). From 2005 to 2007, SDHU led a multi-health unit collaboration advocating for the inclusion of SDH-focused general and program standards into what became the Ontario Public Health Standards. This process is described in Section VIII of this study.

After 2007, SDHU's actions expanded to the identification of evidence-based 'best practices' for the reduction of social inequities in health. In 2008, SDHU staff received multi-year funding from the Canadian Health Services Research Foundation (CHSRF) through its Executive Training for Research Application (EXTRA) fellowship (SDHU, 2009, 2010). This funding was used to undertake an extensive literature search to identify public health practices that were at least 'promising' in their potential to bring about reductions in social inequities in health. This work culminated in the *10 Promising Practices* document designed to assist public health units with the identification of evidence-supported strategies for reducing health inequities and addressing the SDH (Sutcliffe, Snelling and Lacle, 2009; SDHU, 2011).

iii) Analysis of SDHU's Actions on the SDH by Key Components of Multiple Streams Theory

The Problem Stream: Indicators of SDH Deficits

The key social and economic indicators of Greater Sudbury improved over most of the duration of the case. Favourable economic conditions, including a sharp increase in nickel prices in the mid-2000s, were associated with decreased unemployment (from 9.6% in 2001 to 8.4% in 2006), increased home ownership and rising individual and household median incomes that, by 2005, were on par with or better than the corresponding Ontario averages (Burleton, 2007; Statistics Canada, 2006d; Social Planning Council of Sudbury, 2009).

There was also significant progress in poverty reduction among Greater Sudbury residents. In 1986, almost 1 in 6 (15%) families and 1 in 2 (44%) unattached individuals lived in poverty, compared to approximately 1 in 10 (9%) families and 1 in 3 (36%) unattached individuals by 2005 (Statistics Canada, 2006d; Social Planning Council of Sudbury, 2009). It appears that the decreasing rates of poverty during this time frame were having a positive impact on food insecurity. Data collected by the SDHU revealed that the age-standardized prevalence rate of food insecurity decreased from 7.1% in 2005 to 5.2% in 2007-2008, although the latter figure should be interpreted with caution due to high sampling variabilities (SDHU, 2016).

However, the benefits accruing from a robust economy were not equitably distributed among all residents of Greater Sudbury. Although the unemployment rate improved significantly from 1996 to 2006, the rate of youth unemployment (15-24 years) remained consistently high (Social Planning Council of Sudbury, 2009). Moreover, Sudbury's transformation from a resource-based community to a regional service hub exacerbated gender differences in wage disparity and poverty. In 2006, close to two-thirds of Greater Sudbury's female labour force were employed in lower-paying 'sales and service' and 'business, finance and administration' occupations. Female labour force participants in Greater Sudbury reported earnings significantly lower than their male counterparts in all occupations: in 2005, women reported earning 58 cents for every dollar earned by men, a decrease of 4 cents since 2000 (Social Planning Council of Sudbury, 2009). Female lone-parents with dependent children at home (under 18 years of age) had the highest poverty rates in Greater Sudbury, with more than 1 in 2 (54%) living below the Low Income Cut off (LICO) measure in 2005 (Statistics Canada 2006d; Social Planning Council of Sudbury, 2009).

The Problem Stream: Community Awareness

Respondents had mixed opinions about the level of community awareness of the SDH at the onset of the case. The Director of the Health Promotion Division felt that key community characteristics of the SDHU catchment area, such as “*a strong labour focus in the community*” and a “*left to middle leaning*” political culture resulted in greater community awareness of, and concern for, the plight of individuals and families affected by the impact of SDH, such as poverty, housing and food insecurity. However, the health impacts of these conditions did not resonate among the community at large:

“I think the community was aware of the things we now call the social determinants of health, like gaps in housing availability or not being able to afford food or inadequate income....I would say that the community was less aware that the social determinants of health impact health or more specifically the opportunity of health for all....that’s where I don’t think the connection had been made.”

The former Executive Director of the Social Planning Council of Sudbury, by contrast, felt that awareness of the SDH in the community was limited to those in the health and social services sector who witnessed the health impacts of inequitable access to income, food, employment and housing among their clientele, whereas the general public and key decision makers embraced the more reductionist illness-based view of health: “*the people who did that work had the language. But if were talking to politicians or the community at large, health was always about the doctor and the hospital, or being sick or not being sick.*”

The Problem Stream: Focusing Events and Feedback

At the onset of the case, the health and social services sector in Greater Sudbury were still coming to terms with the impact of the Harris-era cutbacks on its most vulnerable

community residents. One SDHU staff person recalled the prevailing feeling among community service providers:

“All the changes caused by Mike Harris created such an uproar in our community - the way the benefits and some of the things from an income perspective were being considered, fundamental needs! Things that individuals needed in order to have the opportunity to be healthy were being removed. So it was a very emotional time.”

Emotions were to intensify in August 2001, when a legislative change enacted by the Harris government contributed to the death of a Sudbury resident. In 1997, the Ontario government passed the *Ontario Works Act*, which, in addition to imposing further restrictions on social assistance benefits and eligibility criteria, instituted harsh punitive measures, including a lifetime ban on welfare collection, for those convicted of welfare fraud (Stapleton, 2015). In April 2001, the full penalties stipulated in the Act were imposed on Kimberly Rogers, a social services student at Cambrian College and expectant mother who pled guilty to receiving student loans while collecting social assistance. Her sentence included six months of house arrest, 18 months’ probation, a three-month suspension from receiving social assistance, the loss of the right to have part of her student loan forgiven, and the re-payment of over \$13,000 in social assistance (Mackinnon and Lacey, 2001).

Kimberly Rogers was able to have her social assistance benefits re-instated in May 2001 after a successful court challenge. But she did not have sufficient income to support herself or her unborn child, and the harsh provisions of her sentence exacerbated her chronic depression. The period of her house arrest coincided with a sweltering summer heatwave that had not abated when Kimberly Rogers was found dead in her apartment on August 11, 2001. She was eight months pregnant (Yourk, 2002).

The health and social services sector in Greater Sudbury reacted with anger and indignation. In an interview with the *Globe and Mail*, Anna Chodhura from the Elizabeth Fry Society of Sudbury, who spent five months supporting Rogers, stated that “*the word persecution isn’t strong enough to call what happened to her. This is a tragic case of putting government policies into practice without doing any research....Two lives are over.*” (MacKinnon and Lacey, 2001, p. F1).

The former Executive Director of the Sudbury Social Planning Council, who subsequently went on to become a municipal councillor and serve as Chair of the SDHU BOH, recalls her frustration with a deeply flawed system and the lack of response from local elected officials.

“Part of it was how can you put somebody under house arrest and cut off their welfare and not allow them to go out and earn money and expect them to live? How did people think she was going to live?...I remember she died in August and a friend of mine was on city council at the time. And I met with him for lunch and I said to him why as a council are you not outraged? Why didn’t the mayor stand up and say ‘not on my watch’? Pregnant women should not die in their apartments in the heat.”

The ED of the Social Planning Council collaborated with other community organizations, including the Elizabeth Fry Society of Sudbury, the Sudbury District Labour Council, the Sudbury Women’s Centre and the Sudbury Community Legal Clinic, to create the *Justice with Dignity* campaign. With the support of national organizations, the campaign successfully fought for a Coroner’s Inquest into Kimberly Roger’s death, which began in October 2002 (Yourk, 2002).

On November 22, 2002, the MOH of SDHU told the inquest that “*it’s virtually impossible to lead a healthy lifestyle if you are a person living on social assistance...There is a direct relationship between living in poverty and poor health. It’s not contested that poverty is*

bad for health.” Using data collected as part of its cost of nutritious food basket program, the MOH noted that Kimberly Rogers would not have \$140 per month, the cost of nutritious food basket for a single person in Greater Sudbury at that time, to spend on food after paying her rent (Lacey, 2002, p. 1). The testimony of the MOH influenced the December 2002 Verdict of the Coroner’s Jury report, which recommended that *“data about the nutritional food basket prepared annually by local health units”* be included in a process to *“assess the adequacy of all social assistance rates...based on actual costs within a particular community or region.”* (Ontario Ministry of Public Safety and Security, 2002, p. 3).

The death of Kimberly Rogers did not serve as a **focusing event** in the sense that it directly initiated SDH-focused activities by the SDHU. Rather, as was previously noted, the MOH had already been reaching out to community groups and making presentations on the SDH for over a year. Nor did it necessarily result in a more sympathetic community climate for social assistance recipients. When recalling the period following Kimberly Roger’s death, the former Director of the Social Planning Council of Sudbury lamented that:

“lots of people blamed Kimberly. It was her own fault. She was the one who had used both systems. People just couldn’t, and still don’t, wrap their heads around the idea that there just isn’t enough money to live off a welfare cheque...and I can remember many letters to the editor from people who were ready to blame her and not the system.”

However, it could be argued that Kimberly Roger’s death did demonstrate some of the key properties of a focusing event. Specifically, it validated SDHU’s commitment to take action on the SDH, galvanized key community organizations against the negative health impacts of government policy and set in motion a series of events that gave the SDHU MOH an influential platform to communicate her views about the SDH. In subsequent years, Kimberly Roger’s story was communicated by SDHU to both illustrate the importance of equitable access to income as

an SDH and to make the case for SDH-focused actions. For example, SDHU's Director of Health Promotion describes how the Kimberly Rogers tragedy inspired the EXTRA project to identify best practices for local health unit action on the SDH:

“And that very important issue - receiving student loans while receiving welfare resulting in a sentence of house arrest and a related death - caused people in our community to rally. The determinant, in this case, was income. So during the EXTRA project we used this as our anecdote - a story that was the spring board for the rest of the project.”

Characteristics of the Policy Entrepreneurs

All of the respondents interviewed for the SDHU case were unanimous in their agreement that the dedication and leadership of the health unit MOH was a critical factor for enabling SDHU's action on the SDH. A former SDHU staff emphasized that the MOH's role as an advocate for SDH-focused practice ensured that the SDH were not lost in the myriad of other mandated issues that health units are required to address: *“so we've mentioned the MOH leadership, which I don't think can be under-estimated. You can't underestimate the value of that, because I think without that it's tough to move a lot of this forward when you have a mandate that requires you to do a thousand other different things, right?”*

The SDHU MOH recalls her early efforts to raise awareness of the SDH in 2000 through community outreach and presentations to key health and social service sector groups. Her **claim to a hearing**, the recognized authority and credibility of a policy entrepreneur to speak on behalf of an issue (Kingdon, 2011), was directed towards encouraging potential community allies to appreciate the health impacts of social and economic issues and fostering intersectoral collaboration:

“So when I came here to Sudbury I think that some of the first community presentations I gave were on poverty and health, really inequities in health, the gradient....the role of public health, I

would have seen that more as advocacy at that point in time, kind of speaking truth to power...trying to work with other sectors so that they would understand those [SDH-related] decisions through a health lens and trying to use that to inform decision making.”

The claim to a hearing exercised by the MOH at that time was favourably received by key community stakeholders. The then CEO of the Social Planning Council of Sudbury recalls the impact of the MOH’s presentation at the Council’s AGM in 2000. In particular, the SDH terminology used by the MOH was viewed as a compelling set of concepts that enabled those working in community services to better articulate the need for their focus on poverty reduction:

“When the MOH came to Sudbury I wasn’t in politics yet. And we had her as a guest speaker at our AGM that year....And I remember us all feeling like somebody had finally given us the language we needed to talk about the work we did....And I remember us all being very excited after that because it was new language. So we were people in the field doing the work, understanding poverty and its impacts. And so that was the beginning of us having that kind of language.”

The other benefit of the MOH’s early outreach is that it served to establish SDHU as a trusted partner and advocate among key community stakeholders addressing the ‘downstream’ effects of inequitable access to key SDH, such as income, food and shelter. The MOH notes that *“the biggest reflection I would have is that they suddenly saw public health as an ally in the work they were doing. And that was refreshing - that now it was not them working in their corners or on the margins or whatever - but now the health system, the local public health system, was speaking out on the importance of that work also.”*

Most importantly, the MOH’s community engagement efforts cemented a key partnership with someone who, over time, emerged as another key **policy entrepreneur** who was instrumental in shifting SDHU towards a more SDH-focused scope of practice. As was noted

previously, the Chair of the Social Planning Council of Sudbury was an early champion of the SDH and played a key role in initiating the Coroner's inquest into the death of Kimberly Rogers. In 2003, she chose to extend her advocacy efforts into the realm of electoral politics, winning election as a Councillor in the Greater Sudbury and serving as Chair of the SDHU BOH for five years. One respondent noted that her appointment as BOH Chair, which came *"at a time when the SDH were really gaining traction at SDHU,"* ensured that *"a social justice lens and an appreciation of the social determinants of health were really strongly present at the Board level."*

Through multiple presentations to both the SDHU BOH and the City Council of Greater Sudbury, the MOH and the BOH Chair displayed the quality of **persistence**, the willingness to invest time and resources into advancing a policy agenda identified by multiple streams theory as a key attribute of effective policy entrepreneurs (Kingdon, 2011). One respondent recalled that the MOH and the BOH Chair were *"both very strategic in ensuring that the Board never lost sight of the determinants of health. As our health unit became increasingly active [in the SDH], we kept re-presenting back to the Board. We kept highlighting impact when we could with them. And I think that was really, really important."*

The Politics Stream

Respondents felt that the SDHU BOH displayed consistently high levels of support for SDHU's SDH-focused work throughout the duration of the case. The strong level of BOH support persisted across two municipal election cycles (2003 and 2006) and the resulting changes in BOH membership. As the Director of Health Promotion noted, *"even when the Board changed, it was always positive and supportive."*

The favourable political climate was linked to two factors. First, Sudbury's left of centre political culture, characterized by a strong organized labour presence in the community and a widely-shared belief in collective action to address social problems, tended to ensure the election of Councillors inclined to be sympathetic towards SDH initiatives. The Director of Health Promotion described the key attributes of a community favourably disposed to SDH-focused action: *"Our community is largely a left-to middle leaning community in terms of the way that it's voted in the past...with the strong labour focus in our community, I have wondered whether or not that has helped shape the way in which our Board or the community in general thinks about these issues...In Sudbury there is a history of working together."*

The second factor concerns the governance structure of SDHU. Like the majority of the local health unit cases in this study (4/5), SDHU is accountable to an autonomous Board of Health that operates separately from the administrative structures of its member municipalities (Association of Local Public Health Agencies, 2015). As was noted previously, this governance model is associated with greater degrees of stability and MOH autonomy (Capacity Review Committee, 2006). The Chair of the SDHU BOH for most of the case concurred with this assessment, noting that:

"Our Board of Health is a strictly governance board that is not involved in operational or organizational things, right? Our role was in setting budgets and supporting the work. So when the MOH would come to the Board with her work plan it would include the work they were going to do on the social determinants of health. As a Board we were very supportive and as the leader of that Board, I was influential with other Board members, making sure we stayed influential in that area [the social determinants of health]."

Like the Peterborough City-County Health Unit, the SDHU pursued an incremental strategy of **institutionalization**, the capacity of policy entrepreneurs to act within political systems over time to advance their agenda (DeLeeuw, 1999). Both PCCHU and SDHU started out with small, revenue-neutral ‘wins’ that laid the basis for more substantive action. In the case of SDHU, the 2003 creation of a Determinants of Health Task Group by the MOH set the stage for the formal endorsement of a Determinants of Health Position Statement by the SDHU BOH two years later. The Director of Health Promotion described how this process helped to institutionalize SDHU’s focus on the SDH:

“Well, one of the first things I remember the MOH asked us to do was develop a social determinants of health working group. And then that working group was asked to develop a position statement to take forward to the Board. The Board supported the position statement without hesitation. Once the Board supported the position statement, it gave our MOH and the health unit the backing needed to focus on the social determinants of health.”

The Policy Stream

The 2005 passage of the Determinants of Health position statement by the SDHU Board of Health was followed by a period of expanded focus on SDH by the health unit. The installation of a Manager of Health Equity in 2006 enabled the creation of strategic and operational plans addressing the SDH. By January 2009, the Determinants of Health Task Group had evolved into a Health Equity Steering Committee with managerial representation across the health unit Divisions. The MOH recalled that these advancements were critical *“to make sure we had the structure in place. So that it’s not just off the side of my desk or someone else’s desk. It’s really in the middle of someone’s desk to move this forward, to move our organization and our staff forward.”*

Yet, in spite of these achievements, the SDHU MOH felt that a vital ingredient was missing by the mid-2000s. Specifically, the dearth of evidence-based practice at that time meant that SDHU lacked the **clarity of directives** vital for SDH-focused actions (Exworthy 2008). The MOH recalls her growing sense of unease about taking a lead role in addressing the SDH in the absence of evidence-based practice:

“And then it kind of struck me that we had Board governance support, we were working on getting the Ministry to require Boards to do this [SDH-focused] work. It just struck me that the emperor has no clothes, right?...okay, local public health, you talk a good talk, but what do you actually do?”

Concern about the need to identify viable, evidence-based actions on the SDH that could be feasibly implemented by local public health units prompted SDHU to apply for multi-year funding from the Canadian Health Services Research Foundation (CHSRF) through its Executive Training for Research Application (EXTRA) fellowship (SDHU, 2009, 2010). As was noted previously, the funding supported an extensive literature search by the health unit to identify public health practices that were deemed to be ‘promising’ in their potential to bring about reductions in social inequities in health. Ten ‘promising practices, which continue to guide the equity-focused work of SDHU at present, were identified:

1. Targeting with universalism (ensuring that extra benefits and supports for greater access are provided to vulnerable groups participating in universal programs.
2. Purposeful reporting of the relationship between health and social inequities in all health status reporting.
3. Social Marketing
4. Health equity target setting
5. Equity-focused health impact assessment
6. Competencies/organizational standards
7. Contribution to evidence base
8. Early childhood development
9. Community Engagement
10. Intersectoral action (SDHU, 2011)

Beginning in 2009, the results of this review, which were eventually published as the *10 Promising Practices* document (Sutcliffe, Snelling and Lacle, 2009; SDHU, 2011), formed the basis of orientation and capacity building activities among SDHU staff. They were also used to develop a multi-year workplan to guide SDHU's work. The Director of Health Promotion observed that *"we identified ten promising practices for local public health and we wanted to make sure that we oriented everyone in house to those...and then in house the MOH formed a steering committee that she chaired. And the steering committee used those ten promising practices to set up a ten-year workplan. That model informs the structure of the health unit's 10 year health equity workplan today."*

The process of getting SDHU staff to incorporate the ten promising practices into their work proved to be challenging in some cases. The task seemed to be particularly onerous for staff focused on health inspection or communicable disease prevention, whose work was (and is) highly prescribed by provincial protocols. The health unit staff responsible for conducting the orientation sessions recalls the inherent difficulties of integrating the SDH into the mandate of certain public health professions:

"When we did the ten promising practices we tried to get teams in each division to focus in on one or two that would be most applicable to their areas. With environmental health and public health inspectors it always seemed there was a very specific response to every type of issue they were presented with....eventually we found a place to think about food safety and food handler training, for example. Like how might these be offered so they were more accessible to folks who might be vulnerable or marginalized...But it just seemed always that much more challenging...you know they were already challenged to just meet their mandate with the protocols they were provided with."

The existence of a strong, dedicated Steering Committee, with leadership from each SDHU division, overseeing the integration of the Ten Promising Practices into health unit services was viewed as critical in overcoming challenges arising from the mandate of specific

public health disciplines. The SDHU staff who facilitated this process notes that *“what really did help us is that we had the health equity team in place, and we found some existing staff champions who we knew already got it...even though we had some pushback, we knew we had some champions there. And when we recruited them on the health equity team, with their level of commitment, I think that was helpful.”*

The implementation of the EXTRA project thus ensured that all SDHU staff had an opportunity to identify the best evidence-based options for integrating the SDH into their scope of practice. The MOH explained how this was critical for ensuring an integrated, comprehensive approach to addressing the SDH throughout the health unit:

“We have used those [10 Promising Practices] relentlessly through the organization to help everybody to see their place or their role no matter what area of work they do, whether it’s talking to the media, or talking to restaurant owners, et cetera, et cetera - to try to see how they can tweak the work they’re already doing to improve health equity....so that people know this is the kind of organization we are, this is the kind of work we are doing.”

Table 7: SDHU Case Summary and Degree of Convergence Between Streams

Component of Multiple Streams Theory	Description
The problem stream	<ul style="list-style-type: none"> • key SDH deficits, including high youth unemployment, food insecurity and gender-based wage disparities, associated with ongoing transformation of local economy from resource (mineral extraction) to service-based. • community awareness of SDH and support for SDH actions positively affected by strong presence of organized labour and a ‘left of centre’ political culture; however, both community members and decision makers tended to equate health with access to tertiary care rather than ‘upstream’ factors. • although the new SDHU MOH had been undertaking SDH-related community outreach since assuming the position in 2000, the 2001 death of Kimberly Rogers, who passed away while serving a house arrest sentence for welfare fraud, served as a focusing event insofar as it validated SDHU’s commitment to focus on the SDH and strengthened ties between SDHU and key community allies.
Characteristics of policy entrepreneurs	<ul style="list-style-type: none"> • SDHU MOH recognized as key leader and champion, with necessary claim to a hearing to serve as a credible advocate for SDH-focused initiatives. • persistence on part of the MOH, including extensive community outreach/engagement, established SDHU as a trusted ally among organizations mandated to address the SDH.
The politics stream	<ul style="list-style-type: none"> • SDHU’s efforts were supported by key political ally, a city councillor and ED of the Social Planning Council who also served as BOH Chair. • Both SDHU BOH and Greater Sudbury Council were supportive, although members of the latter displayed a preference for funding ‘hard’ municipal services (e.g., policing). • SDHU pursued policy of incremental institutionalization to build support for SDH-focused initiatives: creation of an SDH task group that developed a BOH-endorsed position statement that gave SDHU the formal ability to address the SDH within its mandate
The policy stream	<ul style="list-style-type: none"> • ‘ten promising practices’ for addressing SDH within the public health sector (the EXTRA project) identified to give SDHU the clarity of directives needed for effective action. • capacity building conducted to enable staff to locate their role within the context of the ‘ten promising practices’
Evidence of stream convergence (coupling)	<ul style="list-style-type: none"> • partial convergence of problem and politics streams that enabled development of policy solutions over time

8. Towards a Standard Approach to SDH-Focused Actions across Ontario Health Units (2005-2009)

i) Chronology of Events

During the opening decade of the present century, Ontario was hit with a series of crises, including deaths from contaminated drinking water in Walkerton in 2000 and an outbreak of Severe Acute Respiratory Syndrome in Toronto in 2003, revealing the erosion of public health services following years of cutbacks and underfunding. Walkerton and SARS demonstrated that concerns about the systemic neglect of vital public services could not, contrary to prevailing ideology, be dismissed as self-serving advocacy from “interest groups”. Increased awareness of the inadequacy of public health services was a not insignificant factor contributing to the defeat of the Progressive Conservative government in the 2003 Ontario election (Hyndman, 2007)

In June 2004, the new provincial government announced *Operation Health Protection*, a three-year action plan to revitalize Ontario’s public health system (Ontario Ministry of Health and Long Term Care, 2004). Key actions emanating from *Operation Health Protection* included: the establishment of a provincial public health agency, the formation of a committee to provide recommendations for increasing the capacity of Ontario’s public health units, amendments to the *Health Protection and Promotion Act* strengthening the role and autonomy of the Chief Medical Officer of Health, and the incremental restoration of the provincial share of funding for public health unit program and service delivery from 50 percent to 75 percent (Ontario Ministry of Health and Long Term Care, 2009). In addition, a key component of *Operation Health Protection* included the updating of the provincially mandated public health services that had not been revisited for almost a decade (Ontario Ministry of Health and Long Term Care, 2004). A

number of progressive public health leaders, including all of those responsible for the local-level health unit initiatives noted above, seized on this development as an opportunity to secure an explicit provincial mandate for SDH-focused public health work.

Sudbury and District Health Unit responded to health unit interest in this goal by taking the lead in hosting a determinants of health stream as part of the November 2005 Joint Conference of the Association of Local Public Health Agencies (aLPHa) and the Ontario Public Health Association (OPHA). The event was oversubscribed, convening over 100 participants from Ontario health units to collaborate in the development of a proposed SDH framework for the public health mandate. Over the course of five working sessions (see Appendix G), participants shared their experiences with addressing SDH at the local level and reached consensus on proposed General and Program Standards for the Social Determinants of Health (see Appendices H and I). The event concluded with a closing panel where the then-Chief Medical Officer of Health for Ontario, Dr. Sheela Basrur, and the then-Chief Public Health Officer of Canada, Dr. David Butler-Jones, expressed their support for the conference recommendations and continued collaboration between all levels of government on SDH-focused public health initiatives (Lefebvre et al., 2006).

The goal of the proposed General Standard (Appendix H) was *“to improve the health of all of the population by reducing the social, economic and cultural inequities and conditions which cause ill health.”* Proposed program standards and accompanying outcome objectives were created for ten SDHs and related enablers: income inequality, safe and affordable housing, education/skill building/literacy, social inclusion, food insecurity, employment and job security/economy, community capacity/partnerships, access to services, mental health promotion and research (see Appendix H).

The timing of this event strategically coincided with the annual general meetings of aLPHa and OPHA; resolutions calling for the addition of an SDH public health mandate by the province were passed at both sessions (Levebvre et al., 2006). The OPHA resolution (see Appendix I) called upon the “*Chief Medical Officer of Health for Ontario to engage in an inclusive process to examine the role of Ontario’s public health system in addressing social and broader determinants of health*” and asked that the resulting examination “*inform....the review and revision of the Mandatory Health Programs and Services Guidelines...*” The aLPHa resolution (see Appendix J), by contrast, made a more specific request that “*the Mandatory Health Programs and Services Guidelines be revised to include the Determinants of Health as a recognized health program and service area and planning framework for all Ontario boards of health.*”

Building on the momentum generated by this work, a small grant was secured to develop a paper outlining a proposed framework to integrate the SDH into the mandate of Ontario public health units (Lefebvre et al., 2006). To guide the development of the framework, SDHU assembled a reference panel with representatives from eight additional health units (including 3 of the 5 local cases described in this study), as well as the Ontario Prevention Clearinghouse, OPHA, aLPHa, and the Canadian Institute for Health Information (CIHI). This document, combined with the proposed General and Program Standards for the SDH, formed the basis of advocacy efforts targeting decision makers, including the Chief Medical Officer of Health, Ministry of Health officials and members of the Technical Review Committee (TRC) appointed to develop the next iteration of provincial public health unit requirements that became known as the Ontario Public Health Standards (Ontario Ministry of Health and Long Term Care, 2008).

Although this effort proved to be unsuccessful in adding SDH-specific program standards to the mandate of Ontario's health units, it was arguably a key stream of influence contributing to subsequent developments that both mandated local public health units to carry out equity-focused initiatives and increased their capacity to do so. These include: the Foundational Standard of the Ontario Public Health Standards, which specifies equity and SDH-focused planning requirements (Ontario Ministry of Health and Long Term Care, 2008), the requirement of Boards of Health to describe how equity issues will be addressed in program/service delivery and outcomes (Ontario Ministry of Health and Long Term Care, 2011), and the addition of 100% provincially funded SDH nurse positions within health units (Peroff-Johnston and Chan, 2012).

ii) Analysis of Actions on the SDH by Key Components of Multiple Streams Theory

The Problem Stream: Indicators of SDH Deficits

The efforts to incorporate SDH-specific standards into the mandate of Ontario's public health units were not prompted by concern about specific SDH deficits; rather, they arose from a growing concern that the 1997 *Mandatory Health Programs and Service Guidelines* (MHPHG) did not reflect the growing body of knowledge underscoring the importance of the SDH on population health outcomes. Several respondents emphasized that innovative programming addressing the SDH had come about in spite of the MHPHG. One local MOH recalled that "*it was apparent there was nothing really in our Mandatory Program and Service Guidelines*" that enabled SDH-focused practice. Another MOH, upon recalling the circumscribed parameters of the MHPHG for SDH-focused actions noted that "*at first blush, it looks pretty limited...I think the odds look like they are stacked against you.*"

The discussion document accompanying the proposed SDH general and program standards identified the lack of SDH-specific content in the Guidelines as a key system-level deficit in need of remediation. Specifically, the document states that *“The current formal mandate for the Ontario public health system does not include specific program requirements to either mitigate or address underlying social and economic risks to health. The timing is right for the uptake of innovative initiatives that will further the public’s health.”* (Lefebvre et al., 2006, p. i).

The Problem Stream: Community Awareness

For the purposes of this case, the ‘community’ refers to the community of professional public health interests, as the general public was not consulted in the process to revise the mandate of Ontario’s health units. At the time of the case, there was a growing awareness of, and support for, SDH-focused initiatives among health unit staff. The discussion document making the case for SDH-specific standards, which was published in the wake a well-attended provincial session to develop the proposed standards and supportive OPHA and aLPHa resolutions, states that *“staff in public health units have demonstrated a capacity and desire for action in this area. The timing is right for the uptake of innovative initiatives that will further the public’s health”* (Lefebvre et al., 2006, p. i). However, as the ‘politics stream’ section of this case reveals, the lack of support from key segments of the public health sector may have contributed to the ultimate rejection of the proposed SDH standards by the province.

The Problem Stream: Focusing Events and Feedback

The provincial commitment to updating the mandated programs of Ontario health units, announced as part of *Operation Health Protection*, was the focusing event for the proposed inclusion of SDH-specific standards. To make the most of this opportunity, the policy entrepreneurs developed specific program and policy options for SDH-focused work. The SDHU MOH, who led the advocacy efforts for the SDH general and program standards, recalls that “*we didn’t just say ‘please this should be part of the Ontario Public Health Standards’. We provided specific language and were recommending that it be incorporated.*”

Characteristics of the Policy Entrepreneurs

The individuals leading the advocacy efforts for SDH-specific public health standards displayed the three key attributes deemed that Kingdon deemed essential for effective policy change. Respondents noted that the ‘entrepreneurs’, which in this case was a small group of MOHs from local health units, exercised their **claim to a hearing**, built support through **political connectedness and negotiating skills** and demonstrated **persistence** through utilizing multiple opportunities to advance their policy agenda (Kingdon, 2011).

The authority and credibility of MOHs as spokespersons for SDH standards was recognized as a critical factor, both for building support among MOHs at other local health units and advocating to key decision makers at the Ministry of Health and Long-Term Care. One health unit Director, who was closely involved in drafting the proposed SDH program standards, noted that “*MOHs have to bring things to MOHs. People like me can’t bring things to MOHs.*”

To build support for a provincial mandate for SDH-focused public health action, the policy entrepreneurs drew upon their political connections with the key public health interest

groups in Ontario. As was noted previously, the proposed SDH standards were introduced at a joint conference of OPHA and aLPHa in 2005, the two groups representing the interests of Boards of Health and public health practitioners in Ontario, and both organizations passed resolutions endorsing the integration of the SDH into the mandate of public health units. Over the next two years, SDH-focused workgroups in both organizations coordinated efforts to review the emergent draft standards and provide feedback (Seskar-Hencic, 2015; Wai, 2016). The policy entrepreneurs attempted to advance their agenda through targeted communications and requested meetings with Ministry officials as well as through participation on sub groups established by the Technical Review Committee revising the mandated scope of practice for Ontario's health units. (Salvaterra, 2015; Seskar-Hencic, 2015).

The degree of **persistence** required to sustain momentum in advancing SDH-specific standards through multiple venues over a period of years was noted by several respondents. One respondent, a key proponent for the proposed SDH general and program standards, recalls the challenge of balancing his role as an advocate with the time needed to attend to his 'day job' at as MOH of a geographically dispersed health unit:

"I remember a lot, hundreds of hours spent going over draft standards, trying to broaden them to include the social determinants of health, trying to make them part of our mandate... You work on providing services during the day, and then if you want to attend to other things you have to do it in the evening.... And I remember a lot of evenings working with my executive assistant. She'd stay in the office, and we'd do them together - the two of us going through draft standards at ten o'clock at night trying to make them SDH friendly."

Another MOH who worked to advance the SDH standards concurred with the high level of persistence required to get the issue on the agenda of provincial decision makers noted that sustaining interest over time was *"always a challenge. You can sort of get fatigue on a topic. So*

keeping up the interest was a challenge.” He did, however, note that the sustained effort was successful insofar as it captured the attention of provincial decision makers. Specifically, he recalled a conversation with a Ministry official involved in the Technical Review Committee process who expressed “how impressed people at the province were with how coordinated we were back then. And it just seemed to come from all quarters at once that there needed to be action on the determinants of health. And they weren’t used to that, and suddenly it was happening in that kind of way, which I took a special satisfaction in I must say.”

The Politics Stream

The effort to include SDH-specific standards into the mandate of Ontario health units occurred during what, on the surface, appeared to be a highly opportune political climate. Respondents described the era of *Operation Health Protection* as a time of optimism and renewal that allowed for the exploration of new modalities of public health practice, including action on the SDH. One health unit Director recalled the period as “*the heyday in terms of provincial people trying to sort this out and figure out what we could do.*” This view was shared by a Director from another health unit, who noted that the political climate of the day provided an opportunity for progressive changes in public health practice and an impetus for SDH-focused initiatives addressing those in greatest need.

“I remember it was a very exciting time. We all felt really positive that we might be able to create some change. We really believed that it had to happen as we thought about public health and increasing the health of populations. We had to improve the health of everyone, but we had to improve the health of certain population groups faster. So everyone believed that, right? So there was a real impetus to really work on this,”

Yet a favourable political climate at the provincial level was not sufficient to overcome key impediments, which, in hindsight, mitigated against the possibility of SDH-specific public health standards from the outset. One of the most significant barriers was cost. The restoration of the provincial share of funding for public health programs announced as part of *Operation Health Protection* was not sufficient to assuage the concerns of municipalities that were still struggling to cope with the fiscal impacts of the 1997 *Services Improvement Act*, which ‘downloaded’ funding for a range of social services from the province to municipalities (see Section 6 for additional details). Municipalities expressed particular concern that the growing cost of subsidizing health and social service programs was resulting in deferred investments to vital municipal infrastructure, such as roads and bridges. A 2006 pre-budget submission by the Association of Municipalities of Ontario (AMO), the organization representing the interests of Ontario’s municipalities, warned that the cost of municipal contributions to downloaded services, which had reached \$3 billion a year, was resulting in deferred maintenance and delayed investment in infrastructure that was growing at the rate of \$5 billion per year (AMO, 2006a).

Throughout the consultations arising from *Operation Health Protection* AMO did not divert from their position that public health services should be fully funded by the province. In their response to the recommendations of the Capacity Review Committee, AMO described the partial funding of public health programs from the property tax base as “*fiscally unsustainable and what AMO believes is an example of poor public policy.*” (AMO, 2006b, p. 2). Regarding the potential introduction of new public health programs, which would certainly encompass those addressing the SDH, AMO maintained that “*all new measures, functions and any additional administrative responsibilities should be 100% provincially funded, including all transition costs.*” (AMO, 2006b, p. 3).

The provincial government responded to cost concerns with a directive that the revised provincial public health standards be revenue neutral. This was re-iterated in a ‘q and a’ backgrounder accompanying the release of the Ontario Public Health Standards, which stated that *“Ministry staff were directed to develop the [Public Health] standards and protocols within the current fiscal envelope for public health and it is the government’s expectations that boards of health will plan for their adoption within their current funding allocations for mandatory programs.”* (Ontario Ministry of Health and Long-Term Care, 2008b, p. 2). Needless to say, this restriction did not leave a lot of expansionary room for the introduction of activities addressing the broader social determinants of health.

Those advocating for SDH-specific standards were aware of the barriers posed by cost. One of the MOHs actively involved in advocating for the adoption of the SDH standards noted that *“there was certainly pressure to contain the ‘box’ and not make it any bigger than it was going into the writing of the Ontario Public Health Standards. And so I’m sure that’s the reason why social determinants of health didn’t make it into a program standard.”* A Director at another health unit recalled that *“we also knew that the Ministry didn’t want to create a lot of new standards because that was a clear message.”*

While cost was a significant barrier to the adoption of SDH-specific public health standards, it was by no means the only one. Another major impediment concerned differing viewpoints around the primary role of public health services.

While *Operation Health Protection* provided an opportunity for renewal and dialogue about the parameters of public health practice, it’s important to remember that the impetus for the reforms resulting from *Operation Health Protection* arose from communicable disease

outbreaks and deficits in health protection (e.g., Walkerton, SARS), rather than inequitable access to the SDH. The series of ‘post-mortem’ reports on public health sector deficiencies in the wake of SARS shared a common message that the health protection functions of public health needed to be strengthened even if the resources to bolster health protection came at the expense of health promotion and disease prevention functions. For example, *The SARS Commission Interim Report: SARS and Public Health* by the Honourable Justice Archie Campbell, Commissioner, makes the following assertion:

"While it would be wrong to downgrade the long-term importance of health promotion and population health, the immediate threat posed by any infectious outbreak requires that a dominant priority must be given to protecting the public against infectious disease. It does not disrespect the advocates of health promotion to say that the immediate demands of public safety require that public health, as its first priority, looks after its core business of preventing us from infectious disease." (Campbell, 2004, p. 12).

This reductionist view of the role of public health was not limited to the Ontario judiciary. A 2007 survey of 782 elected municipal officials in Ontario found significantly higher levels of support for committing municipal funds to health protection programs than health promotion programs (Reddick, 2007). Out of a possible score of 6, the mean level of municipal support for ‘health promotion’ type public health programs was .77 (>.67 to <.88, 95% confidence interval), while the mean level of support for ‘health protection’ programs was 2.11 (>1.97 to <2.25, 95% confidence interval). Coupled with ongoing concerns about the fiscal impacts of downloading, these results did not favour municipal support for the expansion of public health services that did not meet a health protection mandate.

There is also evidence that the debate about the appropriate scope of public health services extended to the public health sector itself. While both of the key groups representing the interests of public health in Ontario, OPHA and aLPHa, passed resolutions endorsing the concept

of integrating action on the SDH into the mandate of Ontario's health units, it's interesting to note that both resolutions stopped short of endorsing the proposed SDH standards (See Appendices I and J). It may be that both associations wished to maintain a position of flexibility, declining to endorse any prescribed 'blueprint' for SDH-focused practice at a time when the process for revising the key practice document for Ontario health units (i.e., the Technical Review Committee) had not yet been initiated. Or the somewhat tentative language of the resolutions may have served to paper over differences among key stakeholders concerning the extent to which public health units, could, or should, focus on the SDH.

The Council of Medical Officers of Health (COMOH) is a sub-group of aLPHa representing medical and associate medical officers of health at Ontario public health units as well as former medical officers of health with emeritus status (aLPHa, 2016). In 2007-2008, the time during which the Ontario Public Health Standards were under development, COMOH identified the 'social and economic determinants of health' as one of its organizational priorities. Activities undertaken in response to this priority included advocacy addressing the cost of nutritious foods, a deputation as part of provincial pre-budget consultations and a meeting with Deb Matthews, the then-Minister of Children and Youth Services who was chairing a cabinet committee on poverty reduction (aLPHa, 2008).

However, COMOH's apparent support for the SDH did not extend to unqualified endorsement of the proposed SDH program standards. One of the MOHs who led the advocacy efforts to have these standards adopted by the province recalls the tense atmosphere when the topic was raised at COMOH meetings:

“...there were four or five of us Medical Officers of Health who got into shouting matches at COMOH meetings, closed door sessions with other MOHs about the need to do this, and them saying ‘It’s not our job!’ ‘But it should be!’ ‘Well, who the ---- are you to say what should be?’”

The dissension within COMOH regarding the adoption of the SDH standards was confirmed by another MOH who took part in the aforementioned meetings. She noted that some MOHs who did not view SDH-focused activities as part of the ‘core business’ of public health precluded COMOH’s unqualified support for the SDH-focused standards. In practice, this meant that the MOHs who championed the standards had to proceed without the support of their key stakeholder group:

“I didn’t get the sense that there was consensus among COMOH on the social determinants of health. There were still medical officers of health for whom the social determinants of health were not seen as core public health business. There continue to be some medical officers of health who, although they recognize the importance of the social determinants of health, don’t see them as a priority for work. There are competing priorities for public health dollars and time. So given that COMOH wasn’t 100 percent behind the program, I think we did the best we could.”

A final barrier that precluded the adoption of the proposed SDH standards concerns sectoral responsibility. Several respondents recalled concern expressed by Ministry officials over the fact that SDH standards extending into areas such as housing, employment and education could give rise to bureaucratic ‘turf wars’ between the Ministry of Health and the other provincial ministries with a direct mandate to address these determinants. One health unit manager recalls that *“there was still at least a perception that some public health units and Ministry folk were struggling with not wanting to take on the mandate of other ministries. So we don’t want to write explicitly into our mandate anywhere that we’re addressing housing, we’re addressing income, et cetera, et cetera.”* A director at another health unit, who helped to draft the language of some of the proposed SDH program standards, recalls being told by a colleague in social services that the SDH Housing Standard was a non-starter due to jurisdictional issues:

“We had a pretty good relationship with people in our social services department. And I remember talking to them, saying we’re trying to bring this housing standard forward. And they said the social services ministry is never going to let that happen! So whether that was part of it - that we were on the ‘turf’ of other ministries.”

The political barriers precluding the adoption of the proposed SDH general and program standards were discussed at an information meeting between the MOHs and health unit staff championing the standards and key officials from the Ministries of Health and Long Term Care, Health Promotion and Children and Youth Services. The agenda for this meeting, which took place on January 15, 2007, is included in Appendix K.

Health unit participants recall this meeting as the moment when they were informed that the proposed SDH standards could not be adopted as written. One of the pro-SDH standard MOHs in attendance provides the following summary of the discussions:

“Funding constraints, political constraints - we can’t get ahead of the government on these things. The government is not ready for this. Health unit staff and COMO are not willing to take this on as a mandate. And I’m not saying all of the reasons were wrong. They just weren’t about to be the advance guard.”

Another MOH in attendance recalls a sense of disappointment and frustration at the conclusion of the meeting. These feelings arose from a perception that Ministry officials, while ostensibly recognizing the importance of the SDH, placed the impetus on local public health units to come up with workable solutions.

“We were really trying to make the case. It was interesting because at the end of the day it was thrown back to us. We’d done all this work to make the case to government at the time about how to integrate the work that could be done....And I remember being disappointed at the end of the meeting. Although people were nodding their heads and the seeds had been planted, it was sent back to us around what was it that we could do? And really, we’re doing all we can. This is what we need you to do.”

Although the deliberations of the January 2007 meeting made it clear that the proposed SDH standards were not going to be incorporated into the revised scope of practice for Ontario health units, it did not herald the absence of the SDH and health equity in what became the Ontario Public Health Standards. The following section details the policy considerations that led to the underpinning of the SDH into an OPHS Foundational Standard.

The Policy Stream

The policy entrepreneurs championing the inclusion of SDH-specific standards were aware of the need to identify specific, implementable program and policy solutions. One of the MOHs involved in the process noted that the “*biggest barrier to implementation*” was “*that the social determinants of health can mean anything. It’s very broad, so the biggest challenge becomes how do you operationalize it? How to you give it focus?*”

To address this challenge, the policy entrepreneurs ensured that the proposed standards were accompanied by clear directives outlining how the SDH could be addressed in day-to-day public health practice. Six of the proposed SDH program standards, income and income distribution, education, employment, housing, social inclusion and food security, included a list of implementation activities, associated community-level indicators and data sources (see Appendix L). The implementation activities for each standard fell into four broad categories: advocacy, programming, community capacity/partnerships and research/reporting. To ensure linkages to provincial-level data for accountability purposes, measures from a core indicator set developed by the Association of Public Health Epidemiologists of Ontario (APHEO) were utilized. These were supplemented by other available data sources. For example, progress on the food security standard would be assessed through the food insecurity rate, an APHEO core indicator from the Canadian Community Health Survey (CCHS) identifying the “*proportion of*

the population who, because of lack of money, worried that there would not be enough to eat or didn't have the quality or variety of foods that they wanted to eat." (Appendix L, p. 277). In addition, data on the utilization of local foodbanks and the cost of a nutritious food basket would be used to measure progress towards reducing community-level food insecurity.

The proposed activities for implementing the SDH standards were broad in scope, leaving key details about content and strategies to the discretion of local Boards of Health. One of the health unit Directors who was involved in drafting the proposed standards recalls that the somewhat ambiguous language was an attempt to ensure flexibility and responsiveness to local conditions giving rise to SDH deficits:

"We argued that these [the SDH] are embedded issues and that the local context is everything. Maybe not the issue of single moms living in poverty, but the actions you can take and the problems giving rise to poverty are embedded in local communities."

Another noteworthy feature of the proposed SDH standards is the inclusion of advocacy as an implementation activity for action on each of the listed SDHs. The rationale for advocacy as an explicit strategy can be linked to the need for communicating evidence to decision makers across sectors, given the fact that the health impacts of the SDH, such as income, education and employment, are rooted in policies outside the traditional sphere of public health (Lefebvre et al., 2006). However, several respondents recognized that the 'biting the hand that feeds you' implications of a funded advocacy mandate could prove challenging for the province. One of the MOHs supporting the SDH standards notes that:

"Given that so much of the work of social determinants of health is advocacy for policy change, I think there was some discomfort in really giving Boards of Health a stronger mandate because essentially you're giving them a mandate to advocate against the government."

The resulting document specifying the mandate of Ontario health units, the *Ontario Public Health Standards* (OPHS), addressed the political and policy challenges of SDH-focused practice by integrating SDH activities into a set of over-arching or “Foundational” principles underpinning public health practice (Ontario Ministry of Health and Long-Term Care, 2008a). The introduction to the Standards states that “*addressing determinants of health and reducing health inequities are fundamental to the work of public health units in Ontario.*” (OMHLTC, 2008a p. 2). Public health actions towards the reduction of these inequities are specified in the OPHS Foundational Standard, which directs Ontario health units to plan and implement focused interventions to meet the needs of priority populations. Priority populations are defined by the OPHS as those “*identified by surveillance, epidemiological or other research studies*” as “*at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level.*” (OMHLTC, 2008a, p 2).

The OPHS specify that public health initiatives, including those to reduce health inequities among priority populations, are to be guided by the principles of need, impact, capacity, and partnership and collaboration. Of these, the principles of need and impact most directly address health inequity and the SDH. The principle of need requires public health programs and services to consider the needs of the local population. It states “*it is evident that population health outcomes are often influenced disproportionately by sub-populations who experience inequities in health status and comparatively less control over factors and conditions that promote, protect, or sustain their health. By tailoring programs and services to meet the needs of priority populations, boards of health contribute to the improvement of overall population health outcomes. Boards of health shall also ensure that barriers to accessing public health programs and services are minimized.*” (OMHLTC, 2008a, p. 12)

The principle of impact, by contrast, acknowledges the role of Ontario health units in recognizing and influencing the determinants of health and broader societal changes that reduce health disparities and inequities. This principle requires boards of health to consider what barriers exist to narrowing inequities in health. This encompasses examining the accessibility of programs and services to address barriers, as well as assessing, planning, delivering, managing and evaluating programs to reduce inequities in health while maximizing the health gain for the whole population (OMLTC, 2008a).

Those advocating for the alternative of SDH-specific program standards recall that the OPHS were framed as a more holistic, over-arching alternative to mandating specific SDHs as targets for public health action. One PHU Director stated that:

“I think they [the Ministry of Health and Long-Term Care] felt it [the SDH] belonged with every standard. And I also think - to strengthen that more, they decided to put it up front in the OPHS...to say this is a sort of guiding practice overview as you do your work...So I mean in retrospect it could have been six of one or half dozen of another. Like we had thought the social determinants of health could be a standard, but we were also really pleased that it got embedded the way it did.”

Several respondents described the OPHS Foundational standard as a compromise that enabled health units to conduct SDH-focused work while avoiding the political and economic challenges associated with more explicit directives. A PHU Director involved in advocating for the SDH-specific standards noted that *“we felt this was their compromise. It didn’t look like a standard that required a new staff and a new budget and a new everything.”* One of the MOHs championing the SDH standards provided further elaboration on a possible compromise, noting that the lack of prescriptive language in the OPHS gave health units added flexibility to respond to SDH issues: *“so it may be that this is deliberate. That by not being prescriptive, it [The*

Foundational Standard] *provides the opportunity for some boards of health to be much stronger advocates because they're not being restricted.*" The letter of transmittal accompanying the 2008 release of the OPHS reinforces this viewpoint, with its assertion that the *"OPHS reflect a vision for the delivery of mandatory public health programs and services which is intended to achieve provincial consistency where required while fostering local-level flexibility where appropriate."* (OMHLTC, 2008, p. 1).

Reaction to the Foundational Standard among the policy entrepreneurs advocating for SDH-specific standards was generally favourable. Although the OPHS fell short of mandating specific programs and policies addressing the SDH, it was nonetheless viewed as a step forward. One MOH noted that *"once you can quote a 'foundation', you've got an in, which we didn't have up to that point. So it was something."* This view was shared by a Director at another health unit, who described her reaction to the OPHS: *"I was glad for it. It probably wasn't everything I wanted to see, but I thought there was lots of terrain to work with....I don't think where we ended up was a real failure."*

Several respondents noted that the scope and content of the new OPHS directives enabled them to sustain SDH-focused work that had been initiated at their local health units. One PHU Director recalled *"being disappointed initially"* with the OPHS. *"But when we looked through it with our lens we found lots of support for social determinants of health work in our community...as we worked through the document, we teased out as much as we could and moved forward. So we had the support from the Ministry to make the case for all the programs we wanted to continue."* This view was shared by an MOH at another health unit who noted that *"from our end, the work we had done on food systems and built environment actually got codified in the program standards. That was a huge step forward. So some of the work that had*

been more general health work actually became mandated program work. So that was a definite win.”

Table 8: Ontario Case Summary and Degree of Convergence Between Streams

Component of Multiple Streams Theory	Description
The problem stream	<ul style="list-style-type: none"> • advocacy for inclusion of SDH-specific general and program standards arose from recognized deficits of <i>Mandatory Program and Service Guidelines</i>, which did not reflect current knowledge regarding importance of SDH on population health outcomes. • Operation Health Protection, a multi-component public health reform initiative launched by the Ontario government in 2004, served as the focusing event as it included a commitment to updating the mandated service requirements of Ontario health units. • growing awareness of, and support for, SDH-focused actions among health unit staff.
Characteristics of policy entrepreneurs	<ul style="list-style-type: none"> • small, dedicated group of health unit MOHs exercised their claim to a hearing, built support for the SDH-standards through political connectedness/negotiating skills and demonstrated persistence through utilizing multiple opportunities to advance their policy agenda • consensus on SDH standards achieved through day-long conference workshop attended by over 100 participants • two associations representing the interests of the Ontario public health sector, the Ontario Public Health Association (OPHA) and the Association of Local Public Health Agencies (aLPHa) passed resolutions supporting the addition of SDH-focused activities to the mandate of Ontario health units • discussion document accompanying proposed SDH standards used for communication/advocacy with the Technical Review Committee and Ministry officials responsible for developing new program requirements for health units.
The politics stream	<ul style="list-style-type: none"> • ostensibly favourable political climate limited by several factors, including: municipal concern about cost implications (in wake of 1997 provincial service downloading to municipalities); commitment by the Ministry that the new public health standards be revenue neutral; a focus on strengthening health protection functions post SARS; a lack of support among some segments of the Council of Medical Officers of Health (COMOH), a key public health constituency; and implications for inter-sectoral responsibilities between public health and provincial/municipal ministries/departments with direct mandates to address key SDH (e.g., housing, agriculture and food, transportation).
The policy stream	<ul style="list-style-type: none"> • Proposed standards aimed to ensure clarity of directives, including associated activities, indicators and data sources. • Ministry opted to integrate SDH and health equity into over-arching set of ‘Foundational’ principles underpinning all aspects of public health programs/services • Ministry solution viewed as compromise that incorporated SDH into scope of health unit mandate while addressing political barriers and enabling flexibility in response to local needs
Evidence of stream convergence (coupling)	<ul style="list-style-type: none"> • Convergence of problem and political streams. • Interdependence of policy and politics stream (policy options shaped by political considerations).

9. Discussion

As was noted previously, the purposes of this study (see Section 3) were embodied in the following research questions, which collectively formed the basis for the data collection, synthesis and analysis.

1. To what extent do the key constructs of the multiple streams theory define and predict the conditions under which local public health authorities were able to expand the scope of their mandates to address the SDH?
2. Are there key mechanisms within each of the three streams (problem, politics and policy) that appear to be more/less salient in the creation of policy windows favouring SDH-focused public health practice?
3. What were the characteristics and roles of the policy entrepreneurs in advocating for SDH-focused public health practice that enabled or hindered the resulting policy changes?
4. Are there additional factors (theoretical gaps) beyond the parameters of the multiple streams theory that need to be considered when defining and predicting the conditions favourable to SDH-focused public health practice?
5. What practical advice do the identified policy entrepreneurs (e.g., local health unit Medical Officers of Health) and other key actors have to offer about how to influence the opening of policy windows to foster SDH-focused public health initiatives?

A review of the extant literature on the application of multiple streams theory to assess the adoption of SDH-related policies (DeLeeuw, 1999; Gulrandsson and Fossum, 2009; Strand and Fosse, 2011) and publically accessible documentation on the identified cases enabled the creation of nine analytic propositions pertaining to the above-noted questions (see Section 3.2). These propositions provide hypothetical insights regarding the theoretical concepts influencing

the opening, or, in some cases, non-opening of policy windows enabling SDH-focused action by ‘early adopter’ public health units in the opening decade of the current century (i.e., questions 1-3). The following section critically appraises each of these propositions against the study results. Section 9.2 addresses research question 4 by identifying the key contextual factors and mechanisms outside the tenets of multiple streams theory that appeared to be salient in initiating SDH-focused public health practice within and across the cases, while Section 9.3 addresses the fifth and final research question by presenting the implications of the study for SDH-focused public health practice, policy change and further policy-focused research.

9.1 Support for multiple streams theory as a predictor of SDH policy initiation by Ontario health units

The Problem Stream: Focusing Events

Analytic proposition one, that action at some of the local health units was precipitated by focusing events, which resulted in changes in the problem stream, was evidenced in three of the six cases: Leeds-Grenville-Lanark, Sudbury and the Ontario-wide effort to establish mandated SDH public health standards. In the case of Leeds-Grenville-Lanark, the release of the District Health Council report linking an increase in all-cause, age adjusted mortality to a rise in LGL residents living below the poverty line was cited by multiple sources as the key impetus for the creation of the LGL Health Forum (Gardner, Arya and McAlister, 2005; Gardner, 2015; Marshall, 2015). In addition, the Forum appears to have been initiated by a growing unease about the impact of successive funding cuts on the capacity of local health and social service providers to meet community needs (Gardner, Arya and McAlister, 2006; Pickens, 2015). In Sudbury, although SDH-focused community engagement by the SDHU MOH

preceded the 2001 death of Kimberly Rogers, the latter served as a focusing event through validating SDHU's decision to embrace the SDH as a priority health issue and strengthening relationships between SDHU and key community allies (Gasparini, 2015; Sutcliffe, 2015). Over time, SDHU cited Kimberly Roger's death to illustrate the importance of equitable access to the SDH and to build the case for SDH-focused public health practice (Canadian Public Health Association, 2014; Lacle, 2015). At the provincial level, the launch of *Operation Health Protection* in 2004 served as a focusing event insofar as it included a process for re-drafting the document specifying the mandate of Ontario's health units (Ontario Ministry of Health and Long-Term Care, 2004). However, the power of this particular focusing event as a catalyst for SDH-centred public health practice was limited at best: while it provided policy entrepreneurs with an opportunity to advocate for SDH-focused public health standards, the broader context of *Operation Health Protection*, with its emphasis on strengthening provincial health protection infrastructure in the wake of SARS and reviewing the entire scope of public health practice, meant that the SDH was addressed by decision makers as one of a number of competing priorities.

There was no evidence of precipitating focusing events in the other three cases. In Peterborough, a shift towards SDH-focused practice was largely in response to persistent feedback by community activists about the need for the health unit to address the health impacts of worsening social and economic conditions by moving beyond the 'healthy lifestyle' paradigm (McKeen, 2015; Post, 2015). The creation of a Health Determinants Planning and Evaluation Division (HDPED) within the health unit serving the Region of Waterloo arose from a shared concern about the need to reconsider public health services in response to emerging evidence about the impact of the SDH on health (Nolan, 2016; Schumilas, 2015), while the attempted re-

organization of Huron County Health Unit to better address the SDH arose from the shared knowledge, beliefs and values of its two senior administrators (Henning, 2016; Nelligan, 2016).

The absence of discernable focusing events in half of the cases is not surprising, given the body of evidence on the application of multiple stream theory constructs. Kingdon (2011) notes that most of the documented focusing events driving policy change occur within the transportation sector, where deaths and injuries resulting from ‘disasters’ capture the attention of decision makers. By contrast, Kingdon observes that there are relatively few examples of health-related focusing events. Kingdon attributes this to the greater public visibility of health as a universal attribute affecting everyone. Since health is on the ‘agenda’ of the public and policy makers most of the time, it takes a crisis of a greater magnitude to make health a more salient issue of interest (Kingdon, 2011).

It could similarly be argued that the social and economic pre-requisites for good health, such as income, housing, food, employment and education, are unlikely to command sudden attention in the absence of a crisis. Although health inequities and inequitable access to the SDH increased over the duration of some of the cases, these trends were incremental rather than sudden. There were no one-time ‘pre-aggregated’ incidents of SDH deficits (akin to hundreds of people dying in a train crash) that captured the attention of the general public and policy makers, but there was sufficient community concern about the longer-term health impacts of SDH deficits in two cases, Leeds-Grenville-Lanark and Peterborough, to call for public health action.

Another variant of the focusing event discussed by Kingdon concerns the emergence and diffusion of a powerful ‘symbol’ that draws attention towards a trend or subject. In general, such a symbol (much like lived experience) serves to reinforce something people already sense in a

vaguer, more diffuse way (Kingdon, 2011). The focusing event as a symbol is certainly evident in the Sudbury case, where the death of Kimberly Rogers encapsulated growing concern among local community service providers about the cumulative impact of social assistance cutbacks. The symbolic power of this single incident, which illustrated the most extreme consequences of punitive government policy, prompted a Provincial Coroner's Inquest and strengthened the resolve of the local health unit to take action on the SDH.

The Problem Stream: Indicators of SDH Deficits

Analytic proposition two, that changes in the problem stream enabling local level action were also influenced by the increased collection and dissemination of information tied to key indicators – specifically, population-level data on the SDH, was supported by just one of the six cases. In Leeds-Grenville-Lanark, the health status report by the local District Health Council, which was also cited as a focusing event, gave rise to the creation of the LGL Health Forum and guided its inter-sectoral planning (Gardner, Arya and McAlister, 2005; Gardner, 2015).

In the remaining cases, a more concerted effort to collect and disseminate SDH-focused data followed, rather than preceded, a formal health unit commitment to take action on the SDH. Kingdon (2011) notes that decision makers utilize indicators in two different ways: to assess the magnitude of a problem and to become aware of changes in a problem. While there was growing evidence of the relationship between equitable access to the SDH and health outcomes by 2000, the local public health units, as early adopters, lacked the capacity to fully document and monitor SDH trends within their catchment areas. Over time, these health units built the infrastructure to better collect and disseminate this data as a key component of their policy solutions. For

example, a key function of Waterloo's Health Determinants Planning and Evaluation Division entailed supporting community groups with health-related data requests and analyses, while Huron County Health Unit produced a comprehensive community health status report highlighting key SDH indicators (HCHU, 2009) that would have served as a basis for subsequent community engagement had HCHU's restructuring efforts been allowed to proceed. The importance of collecting and monitoring SDH-related data was also recognized by the policy entrepreneurs advocating for provincial SDH public health standards, as 'research/reporting' was included as an implementation activity across each proposed standard (Lefebvre et al., 2006).

The decision to invest in data collection and dissemination as part of the health units' response to the SDH was well received by community organizations and decision makers alike. One health unit Director described the benefits emanating from a decision to disaggregate data in an effort to make it more accessible and meaningful to local decision makers:

“So instead of reporting the mean in our health status reports, our health unit began to disaggregate the data, so people making decisions based on those health status reports would be able to make informed decisions from different population perspectives. And so as our health unit started to create reports using disaggregated data they became well received by municipal politicians and municipal councils.”

Community Awareness

Although not explicitly addressed in the analytic propositions generated for this study, community awareness is an important dimension of the MST's problem stream (Kingdon, 2011). General public awareness of the SDH and their impact on health was perceived as being uniformly low across all of the cases. Only one of the cases, PCCHU, attempted to measure community awareness over the course of its efforts to address the SDH (See Section 7.1), and the

results proved to be discouraging (Post, 2015). A number of respondents pointed to the broad, somewhat nebulous nature of the SDH and the academic, jargon-laden terminology used to describe them as key barriers to raising community awareness. Moreover, the tendency of the general public to equate ‘health’ with access to hospitals and physicians was cited repeatedly as an impediment to building awareness. A former BOH Chair and community advocate identified both of these limitations in her observation that the SDH *“needs to have a new name...because to the ‘average Joe on the street when you talk about health, they do not move beyond disease. It’s too wordy, too academic....when you start with ‘determinants.’ That’s a four syllable word. It’s not an easy concept to get people to wrap their heads around.”* An MOH noted that he made a conscious effort to raise awareness of the SDH in his community *“without using that jargon. I only used that jargon with staff and even then very carefully.”*

The level of awareness needed for meaningful advocacy, engagement and collaboration with the public health sector was limited to health and social service providers and community advocates focused on specific determinants, such as income or housing. In Peterborough, the level of awareness and dedication among these stakeholder groups proved to be instrumental in influencing PCCHU to focus on the SDH as a priority (McKeen, 2015; Post, 2015). In three of the other local cases, Leeds-Grenville-Lanark, Sudbury and Waterloo, the segment of the community engaged in SDH-related work welcomed the new resources, supports and opportunities for collaboration offered by their local health units (Gardner, 2015; Lacle, 2015, Nolan, 2015; Seskar-Hencic, 2015). An exception to this pattern existed in Huron County, where low awareness of the SDH among community members and service providers alike was a major impediment to HCHU’s SDH-focused restructuring efforts (Henning, 2016; Nelligan, 2016).

Kingdon (2011) identifies community opinion as an element of **feedback** about the operation of existing programs/policies related to the problem or issue under consideration. Conditions giving rise to feedback that help to define a problem include the failure of a program/policy to meet its stated goals, the cost of a program/policy or unanticipated consequences of a program/policy (Kingdon, 2011). It is not clear that any of these factors were operative during the onset of the local cases: in 2000 local public health units in Ontario were not mandated to address the SDH, nor, with the exception of Peterborough, did community residents expect them to be proactive in doing so. Considerations of goals, cost and consequences did shape feedback once the health units had begun to implement SDH-specific programs and policies, which supports recent proposals for broadening the focus of multiple streams theory beyond policy adoption (its traditional domain) to the explore the interplay between adoption and implementation (Weible and Schlager, 2016; Zahariadis and Exadaktylos, 2016).

Characteristics of the Policy Entrepreneurs

Analytic proposition three, that Medical officers of health at the local health units played a critical role as policy entrepreneurs, was evident in four of the five local cases as well as the provincial case. The exception to this pattern occurred in Peterborough, where the MOH for most of the case played a supportive, rather than a lead, role in initiating SDH-focused actions within PCCHU (Hubay, 2015; McKeen, 2015; Post, 2015).

The importance of a supportive MOH in initiating SDH-specific health unit strategies was confirmed in a study of nine regional and urban Ontario health units that varied according to their level of SDH-focused strategies (Raphael, Brassoloto and Baldeo, 2014). Using a mix of document review (e.g., mission statements, reports) and qualitative interviews with MOHs and

key staff, the authors concluded that the key factors differentiating the dedication of PHUs to addressing the SDH were the ideological commitments held by MOHs and staff and the organizational structures established by PHUs to implement SDH-related activities. The data of the present study support these assertions, with the caveat that in the historical development of SDH-focused public health practice, the former (ideological commitments of MOHs and key staff) was critical in achieving the latter (SDH-specific organizational structures).

Raphael, Brassoloto and Baldeo (2014) defined the degree of ideological commitment to addressing the SDH as a function of one's theories of justice, society and the underlying causes of health inequities. A noteworthy finding of the present study is that the majority of MOHs interviewed (4/6) identified lived experience rather than scientific literature as the key factor influencing their ideological commitment to addressing health inequities and the SDH. When asked to identify how they first became aware of the SDH, MOHs cited a wide range of seminal studies and practice documents, including the Whitehall Study (Marmot et al., 1978), *Achieving Health for All* (Epp, 1986), and the *Ottawa Charter for Health Promotion* (World Health Organization, 1986). Key innovators in the fields of health promotion (e.g., Trevor Hancock), population health (Fraser Mustard) and SDH research (Michael Marmot, Dennis Raphael) were also mentioned, though, somewhat interestingly, no respondent named the same individuals. But these influencers appeared to be secondary to their early experiences as physicians working with vulnerable populations. For example, one MOH recalled that her "*work as a family physician with immigrants and refugees and low income families in Toronto*" first raised her awareness of "*the link between determinants of health such as housing and education and the outcomes and health potential for my own patients.*" Another MOH described how his ideological commitment to SDH action arose from his work with at-risk youth:

“It always struck me, for example, when I was doing medical consultation work for the youth detention home, that the kids all came from very compromised circumstances, very difficult family dynamics and low income, low socio-economic status. It was quite obvious to me that they weren’t your upper socio-economic kids, upper middle class children. That just wasn’t the case.”

Although caution should be exercised in generalizing this finding to the larger population of Ontario MOHs given the study limitations (qualitative inquiry, small sample size), it does appear that lived experience, in the form of direct encounters with marginalized communities, was a key factor that distinguished these ‘early adopter’ MOHs from public health physicians with more reductionist and traditional views of public health practice. Lived experience may have been a key predictor of both ideological commitment to addressing the SDH as well as a willingness to act as policy entrepreneurs advocating the adoption of SDH-focused public health strategies.

In describing their efforts to advocate for SDH-focused public health practice, respondents supported Kingdon’s claim that **persistence**, the continued investment of time and resources to promote ideas in multiple fora, is the most important attribute of an effective policy entrepreneur (Kingdon, 2011). The institutionalization of SDH-focused structures and strategies within the ‘early adopter’ health units can be most accurately described as a series of incremental gains that emerged through concerted efforts to build an evidence-based case for decision makers, community allies and staff alike. One MOH noted that consensus on the importance of addressing the SDH *“took quite a bit of time with repeated dialogue with partners about the importance of the determinants of health and repeated production of reports and health assessment studies and that kind of thing where we repeatedly called attention to the determinants of health.”* As was noted earlier, a Director who led the process of implementing

an SDH-focused structure within her health unit described the importance of persistent, ongoing communication about SDH-related initiatives to the point where it became accepted as normal health unit practice.

“And the other thing I kept doing regularly - and I was insistent on it with the staff - was to highlight various aspects of the social determinants in our monthly board reports - what was happening with housing, what was happening with our food audit and our food action programs...I put a social determinants spin on all our reports....So when I would talk to board members about this, it was like ‘well, this is nothing new.’ We’ve been putting it in your board reports for years....And so we were able to tie all those kinds of projects in and keep building the case until it became the regular business of what we did at the health unit.”

The importance of persistence in the efforts of policy entrepreneurs to secure a provincial SDH standard in 2005-2007 was addressed in **analytic proposition four: at the provincial level, the activities of the policy entrepreneurs reflected the persistence and protracted ‘softening up’ process necessary to achieve change** (Kingdon, 2011). The study results do not provide sufficient details to fully assess this proposition due to the inability of Ministry officials to disclose confidential information (i.e., the deliberations of the Technical Review Committee that developed the *Ontario Public Health Standards*). While there was evidence of persistence among the policy entrepreneurs, who carried out a multi-year consensus building process utilizing workshops, a discussion document, supporting resolutions from OPHA and aLPHa and information briefings with Ministry officials, the magnitude of barriers in the political stream (see Section 8) circumscribed the range of options for addressing SDH and health inequities within the provincial public health mandate.

The Politics Stream

When asked to consider the range of political factors facilitating or impeding SDH-focused action, the governance structure of the local health unit was cited as a key factor by multiple respondents. As was noted previously, four of the five ‘early adopter’ health units were governed by an autonomous Board of Health operating separately from the administrative structures of its member municipalities. Several respondents noted that this model allowed for a greater degree of MOH independence in setting public health priorities. As one MOH, now retired, noted:

“At that point, and still, Ontario public health units have the most autonomy of anywhere in the country. it’s the only set up where Medical Officers of Health do not work for the government. You don’t work for the province. You report to an independent Board. You could not have somebody in the Minister’s office phone and say stop it or we will fire you!...I knew that as Medical Officer of Health I would have some control over the other frogs in the small pond.”

Respondents from two of the local cases, Sudbury and Peterborough, cited their autonomous Board structure as an asset in enabling them to proceed with SDH-focused initiatives (Salvaterra, 2015; Gasparini, 2016). However, Region of Waterloo Public Health, the one health unit in this study operating under the direct administration of regional government, also saw their governance structure as an asset due to the direct alignment of the regional mandate with key SDH issues and a greater knowledge of these issues among regional councillors (Nolan, 2016). It thus appears that, while an autonomous Board of Health model seemed to facilitate innovative steps to address the SDH, other governance structures could also be amenable to action if the right combination of factors were in place.

The active support of political allies was another critical factor that enabled SDH-focused initiatives in the local cases. The health units in Sudbury, Peterborough and (for a time) Huron benefitted from engaged, supportive Board of Health Chairs and elected officials who actively championed SDH-focused health unit proposals. As the Huron case illustrates, the loss of a key local level champion, who stepped down as BOH Chair and County Warden, dealt a death blow to HCHU's attempt to integrate SDH-focused practice into their organizational structure (Henning, 2016; Nelligan 2016; Shewfelt, 2016).

The role of barriers to SDH-focused action in the politics stream is addressed in **analytic proposition 5: Key barriers in the political stream reflect tensions between the long-term nature of progress on the SDH vs. political demand to see short-term results. Barriers in the political stream also include the fact that SDH-focused solutions are not revenue neutral, which limited their political saleability in a climate of fiscal restraint** (Lefebvre et al., 2006). There was little evidence of the former, political tension arising from demand to see short-term results relative to the time required to make meaningful progress on increasing equitable access to the SDH. This is likely due to the exploratory, developmental nature of the initiatives pursued by most of the early adopter health units: with a few exceptions, these health units primarily sought permission to establish structures and staff positions to aid in the identification of SDH strategies rather than advocating for specific, pre-determined solutions. A health promoter described the early SDH work at her health unit as *“an evolutionary process for us to figure out how it could happen and how to engage staff and gradual training. I think some of these things just take time.”*

Nor was there universal confidence that public health units would be able to identify effective, evidence-informed strategies for addressing the SDH. As was noted earlier, one MOH

recalled her concern *“that the emperor has no clothes...if we were to say, ok, local public health, you talk a good talk, but what do you actually do?”* Given the nascent stage of SDH-focused public health practice at the time of the cases, the policy entrepreneurs at the early adopter health units wisely chose to circumvent potential conflicts about short vs long-term outcomes by not promising more than they could deliver.

The second part of **analytic proposition five, barriers in the political stream also include the fact that SDH-focused solutions are not revenue neutral, which limited their political saleability in a climate of fiscal restraint**, was partially supported by the study data. Kingdon (2011) notes that budgetary implications are a key barrier to the acceptance of new policies, with many policy issues failing to reach agenda status due to fiscal constraints. As was noted previously, concerns about potential costs from key stakeholders (e.g., AMO) was a key barrier to the adoption of SDH-specific standards at the provincial level. In the case of the local health units, cost concerns became more pronounced during the implementation phase as the fiscal implications of their innovations became more apparent.

Although all of the local health units benefitted from BOHs that were either supportive or neutral about their SDH-focused work, the same could not always be said of their regional/municipal councils, the higher level of government that approved the local contributions to the health unit budget. For example, one former BOH Chair recalls budget deliberations where some councillors displayed a marked preference for what were perceived as more essential municipal services over ‘softer’ health unit expenses.

“It was always interesting because the MOH would come to budget night at Council the same night as the Chief of Police would come. And the Chief of Police would come in his regalia....and he’d say that the police department needed five percent more. And no one asked questions. Everyone said ‘good job Chief. You’re keeping us safe’...And then the MOH would

make her plea. And it was like - oh my God - councillors would grill her. 'As if the health unit needs another two percent! Money doesn't grow on trees around here!' It was comical really."

One health unit Director recalls how the perception of SDH-focused activities as 'soft' services with intangible outcomes by some Regional Councillors increased the vulnerability of her portfolio during budget deliberations: *"any time there was 'find ten percent, find twenty percent [in savings], it was always us who were under the eye because we didn't really do anything."* Frustration about the lack of support from municipal/regional councils due to cost concerns was shared by a community advocate from another health unit who described *"a difficult, uphill struggle to get some of these issues onto the Council table...we have always been faced with the questions of why should we do that, we can't afford it, it's too expensive...nobody else is doing it."*

Concerns about the cost implications of SDH-focused public health practice were closely linked to the prevalent political ideologies of local decision makers. In his discussion of ideology as a factor affecting public policy outcomes, Kingdon (2011) cautions against a tendency to define ideology solely in terms of attitudes about the appropriate role and size of government. Kingdon notes that the ideologies of policy makers and elected officials are the product of a number of components, including equity. Proposals sometimes assume a place of prominence on government agendas if they are seen as a means of redressing inequities, imbalances or unfairness. Even in instances where equity is not a driving force for policy change, fairness or the rectification of imbalances often surface in arguments for and against policy proposals (Kingdon, 2011).

Kingdon's notion of equity as a key component of ideology is certainly relevant in the present study. However, it is important to note that support for equity in principle does not necessarily entail the acceptance of progressive, redistributive social and economic policies. One MOH recalled a presentation he gave to his BOH advocating for greater investment in early years and school readiness programs for disadvantaged communities. While supporting the need for action, some BOH members favoured a more neoliberal approach to reducing health inequities:

“And some of the counters back were ‘well, in order to help the poor we have to reduce taxes. So, therefore we’re going to do what we can to reduce the budget of the health unit so we can reduce taxes. Give a tax break to the poor. So that’s how it would turn itself around and come right back at us. The whole idea of redistribution of wealth was not on the radar.’”

Respondents also recalled instances where ideological perceptions about fairness and redress superseded the empirical evidence used to make the case for SDH-related actions. For example, one Director, whose health unit encompassed a rural area, recalls an instance where her food security proposals sustained objections arising from a perceived imbalance favouring one group (small scale farmers) rather than the underlying evidence:

“It was a food-related thing and somehow I was before Council making the case...it was primarily for small-scale farms, which we were losing so quickly...and I referenced the National Farmers’ Union Statistics. And there were a couple of very conservative members of council from rural communities who were not questioning the accuracy of the numbers, which is where my head was, but questioning what they saw as - I think the term ‘socialist mentality’ was actually used. And so I fell into that one.”

The necessity of having to address fiscal and ideological concerns about SDH-focused public health initiatives through a process of negotiation and compromise is addressed in

analytic proposition 6: Within the political stream, the activities of the policy entrepreneurs may have reflected a protracted process of bargaining and trade-offs from ideal positions in order to gain wider support (Kingdon, 2011). Although the study identifies specific instances of compromises from desired positions, such as PCCHU’s revisions to their food security proposal to gain the necessary provincial support (see Section 7.1), the data does not reveal a clear pattern of negotiated solutions across the local health units. This is, in part, due to the fact that the “ideal positions” noted in the proposition were far from clear at the onset of the cases due to the prevailing dearth of evidence about effective SDH strategies within the public health sector. Rather than presenting decision makers with specific SDH policy requests, four of the five cases (Peterborough, Waterloo, Huron and Sudbury) initially sought the resources, staffing and infrastructure to better identify local SDH deficits and effective remediation strategies. In addition, the presence of favourable circumstances in these cases mitigated the need for protracted negotiation to initiate SDH-focused activities. These included the existence of gapped positions in Waterloo (which enabled the health unit to staff the HDPED without budgetary approval) and the presence of key political champions in Peterborough, Sudbury and (for a time) Huron.

As was noted previously, two of the local health units, SDHU and PCCHU, surmounted concerns about costs and other political barriers through an incremental strategy of **institutionalization** that legitimized the SDH as a public health priority. Over a period of time, small, revenue neutral milestones, including the BOH adoption of SDH-focused resolutions and the creation of SDH committees in both health units formally established the SDH as a priority and enabled further expansion and the development of more SDH-focused initiatives (Lacle, 2015; McKeen, 2015).

The Policy Stream

Aspects of the policy stream affecting the adoption of SDH-focused initiatives by the health units in this study are addressed in analytic proposition 7: **Barriers in the policy stream limited the reach and impact of the local level initiatives. These include: the blurring of responsibility and accountability for action due to the multi-faceted nature of the SDH, the lack of diversity among the PH workforce, and the lack of capacity for SDH-focused action among the PH workforce during the time in question (Lefebvre et al., 2006). Barriers in the policy stream also reflect the challenge of providing policy makers with a clear direction for SDH-focused solutions (Exworthy, 2008).** All of these impediments to policy development were evident in the data. But the over-arching barrier, which fuelled concerns around accountability, health unit capacity and the diversity of workforce knowledge and skills, was a lack of clarity around the appropriate parameters for SDH-focused public health practice. Simply stated, although the policy entrepreneurs understood the impact of social and economic conditions on community health status, the sheer breadth of the SDH (many of which extended well beyond the legal mandates of public health units) proved to be a daunting obstacle for policy development. In describing the magnitude of this challenge, one MOH noted that the *“biggest barrier to implementation”* was that *“the social determinants of health can mean anything. It’s very broad, so the challenge becomes how do you operationalize it? How do you give it focus?”*

The absence of clear directives for SDH-focused action during the formative stages of the local cases proved to be a recurring source of frustration for health unit staff. Multiple respondents noted that many staff struggled with the notion of addressing the SDH in their day-to-day work. One health unit Director recalled that *“staff were saying we understand [the SDH],*

but we don't know what to do. What should we do?" A Director at another health unit described an instance during the early stages of SDH-focused planning where staff uncertainty surrounding the implications for practice resulted in a direct confrontation:

"And of course people don't want to 'cocoon' and think - they want to act. I'm just trying to balance that. And I remember a public health nurse was just in absolute frustration one day - she kind of burst into my office. She said 'what exactly does this mean? Does it mean like say hello? What does it mean?' And I was just staring at her like....you know, let's figure out what it means."

To ensure a greater level of clarity around SDH-focused public health practice, four of the five local cases, Peterborough, Waterloo, Huron and Sudbury, invested in priority setting and capacity building activities involving both staff and community allies. While the nature of these activities varied considerably among the health units, initiatives common to all of these cases included training sessions that enabled staff to better address the SDH within their respective roles and the delineation of specific priorities for action. There was a general consensus among respondents that building organizational capacity was a critical step towards the operationalization of SDH-focused practice, with the caveat that it took time for the health units to fully absorb the knowledge.

Four of the five local cases (Huron, Peterborough, Sudbury and Waterloo) addressed deficits in capacity through the creation of new positions with skill sets, such as community development, social work, and urban planning, which differed from health unit staff from more 'traditional' public health disciplines (e.g., public health nursing or health inspection). Several respondents noted that the increasing diversity of the health unit workforce was an initial source of friction among some of the existing health unit staff. One health unit manager recalled *"the tension between public health nurses and these health promotion officers and planners because*

we, all of a sudden, created a multi-disciplinary environment...So all of a sudden public health is looking different. And that was probably looking very, very threatening.” A health unit Director, who oversaw the recruitment of staff with the skill sets needed for the new SDH-related priorities, observed that the process of creating a more diverse work force *“just ruffled endless feathers....very quickly I got the reputation as being the ‘nurse hater’. And public health nurses are amazing, but I had some of them on the team and it wasn’t the only skill set that I needed.”*

But resistance to change on the part of some health unit staff did not ultimately impede the implementation of the SDH-focused initiatives described in this study. Over time, the creation of SDH-focused coordinating committees with representation from all health unit disciplines (in Peterborough and Sudbury), the establishment of formal administrative structures with clearly delineated functions and staff roles (in Huron and Waterloo) and the aforementioned capacity building activities collectively helped to diffuse staff concerns while increasing their comfort level with working to address the SDH through a multi-disciplinary matrix (McKeen, 2015, Lefebvre, 2015; Seskar-Hencic, 2015; Henning, 2016).

Kingdon (2011) describes the generation of policy alternatives as a process of selection, comparable to evolutionary natural selection, where some policy options are marked for ‘survival’ through the imposition of criteria such as technical feasibility, congruence with community values, anticipation of future fiscal constraints and political support (Kingdon, 2011). All of these factors were evident in the policy decisions determining the scope of SDH-focused initiatives in the local and provincial cases, with the caveat that the lack of evidence on ‘effective’ public health strategies to address the SDH meant that the ‘ask’ of the policy entrepreneurs usually entailed the establishment of health unit structures and functions (e.g.,

enhanced data collection capacity to better identify the health deficits of vulnerable community groups), rather than specific policy solutions for ensuring more equitable access to the SDH.

The one policy strategy pursued by almost all of the cases (excepting Huron) was advocacy. Although advocacy is more commonly regarded as a means to achieving policy goals rather than a specific policy option, the public health sector has long regarded advocacy as a critical strategy for ensuring the development of laws, regulations, and practices conducive to the health of individuals and communities (Chapman, 2001; Lefebvre et al., 2006; Cohen and Marshall, 2016).

At the local level, there was considerable variance in the approaches to advocacy utilized by the health units. In Peterborough, a more permissive political climate seemed to enable direct advocacy for more equitable access to the SDH by health unit staff as well as the more traditional approach of advocacy through resolutions adopted by its BOH. Sudbury also pursued advocacy through BOH resolutions, while Leeds-Grenville-Lanark engaged in advocacy as part of a multi-stakeholder coalition mandated to address the SDH. Waterloo, by contrast, focused on building the advocacy capacity of local organizations with SDH-related mandates.

As publicly funded entities accountable to two levels of government, the local health units had to navigate the complex dynamic of ‘advocacy from within’. In practice, this sometimes meant that health units had to provide more covert supports to community-level advocacy initiatives. For example, one health unit Director recalled that:

“given that we work ostensibly within government....you always have to keep everything in kilter in bureaucracies, you can’t rub anything the wrong way...So what can we do ‘off the desk’ that we don’t ever get attributed to in a formal way? ...so the quiet supports...You know, alternative budgets. You know, we’d have community groups involved in that and they would call and I’d say I can give you three days of someone’s time to work out the calculations...nobody would ever

know that. No name would ever appear on the document that the public health unit had done that.”

The importance of advocacy as a public health strategy was recognized by the policy entrepreneurs encouraging the adoption of provincial SDH standards. Advocacy was listed as a key implementation activity for each of the SDH-focused program standards (Lefebvre et al., 2006). However, the potentially sensitive scenario of publically-funded organizations lobbying against government policies likely caused the MOHLTC to approach this proposal with caution. The term ‘advocacy’ does not appear in the *Ontario Public Health Standards*.

Stream Coupling and Independence of Streams

Analytic proposition 8 addresses the issue of coupling, the full or partial convergence of the three streams identified by Kingdon (2011) as a requisite condition for placing issues and policy solutions on the agenda of decision makers. The proposition states that **it is not certain whether a full coupling of the three streams took place in each of the identified cases. The implementation of SDH-focused initiatives at some of the local public health units may have resulted from a “partial coupling”, a convergence of two streams. In these instances, the impact and sustainability of the resulting actions were limited by barriers in the third stream.**

Data from the local cases indicate a full or partial coupling depending on how one defines the parameters of the policy stream. As was noted previously, the local health units, as early adopters, struggled with a dearth of evidence on effective public health strategies to address the SDH (Gardner, 2015; Sutcliffe, 2015). Consequently the policy proposal or ‘ask’ tended to be developmental in nature: the policy entrepreneurs at the local health units secured resources and organizational supports that, over time, enabled them to identify SDH priorities and remedial

actions. A full coupling within the local cases may have arguably occurred only if one defines ‘policy’ in the broadest sense.

There is, however, more compelling evidence of a partial coupling between the problem (awareness of SDH deficits) and political (supportive BOH members and community stakeholders) streams that enabled the local health units to innovate and explore potential policy options. For example, the MOH who led the creation of the Leeds-Grenville-Lanark Health Forum describes the favourable climate for action created through the intersection of a demonstrable problem and political support from key community groups: *“We had this data showing a problem. We had leadership of these agencies that could see the problem and understand it and were concerned about the determinants of health and how the environment that was prevailing at the time was undermining the determinants of health...I think they were more than happy to be part of an enterprise to galvanize action on the determinants of health.”* Another MOH described her success in advancing the SDH agenda as a fortuitous combination of increased support for innovative public health practice (the problem stream) and an increasingly favourable political climate in the wake of *Operation Health Protection* (the political stream).

“There was great interest internally in trying something different and being innovative. And it also was a good time for public health. We were just on the brink of a decade of increased resources. And we had commitment to trying something new... so part of the success is seizing the moment.”

As was noted previously, Kingdon (2011) maintains that partial couplings of streams are less likely to arise on the policy agenda. Yet it appears that the convergence of problem and political factors was sufficient to initiate and sustain multiple years of SDH-focused initiatives by the local cases.

One possible instance of full stream convergence (problem, politics and policy) occurred in Peterborough, where PCCHU was able to secure provincial funding for a multi-year food security initiative (see Section 7.1 for additional details). However, this policy ‘win’ occurred several years after PCCHU had secured formal BOH support to address the SDH as priority. This example illustrates the importance of expanding the use of multiple streams theory to assess the ongoing implementation of policy, as shifting combinations of the three streams can affect how policy priorities are operationalized over time (Weible and Schlager, 2016; Zaharidis and Exadaktylos, 2016).

Coupling between streams in the provincial case is addressed by analytic proposition 9, which states that **a full coupling may not have been achieved due to barriers in any one of the three streams. These include: accountability challenges arising from the multi-sectoral nature of SDH work (policy stream), concerns about the revenue implications of solutions (politics stream), the long term nature of SDH outcomes (politics stream), a lack of public perception/understanding of links between health status and the SDH (Canadian Institute for Health Information, 2005), and timing relative to other issues on the agenda of public health decision makers, especially the need to strengthen provincial capacity for communicable disease control in the wake of SARS (problem stream).** All of these barriers to a full coupling were evident in the analysis of the provincial case. Like the local cases, the opportunity to advocate for SDH-specific standards and the resulting creation of the OPHS Foundational Standard could be viewed as a partial coupling of the problem and politics streams, with the caveat that the problem stream extended well beyond the SDH to examining the entire scope and structure of public health practice in Ontario.

Analysis of the Ontario case data surfaced the issue of stream independence versus inter-dependence. As was noted previously, Kingdon (2011) maintains that each stream operates independently, only interacting with other streams during open ‘windows’ of opportunity. This view has been challenged by other political scientists, who maintain that what Kingdon describes as the three streams, especially the policy and politics streams, are more closely related or inter-dependent (Sabatier, 1988; Mucciaroni, 1992). The possible inter-dependence (as opposed to independence) of streams is most strongly supported in the provincial case, as multiple political considerations circumscribed the range of policy options for integrating the SDH into what became the *Ontario Public Health Standards*.

Table 9: Summary of Local and Provincial Cases by Analytic Propositions and Key Components of MST

Analytic Proposition/MST Variable	PCCHU	LGLDHU	RoWPH	HCHU	SDHU	Ontario
Action precipitated by focusing events arising from changes in problem stream	No	Yes	No	No	Yes	Yes
Changes in the problem stream initiating local level action influenced by collection and dissemination of information tied to key indicators – specifically, population-level data on the SDH	No	Yes	No	No	No	No
High community awareness of SDH deficits	No	No	No	No	No	No
Feedback on limitations of existing public health programs influenced PHUs in refocusing their services to address the SDH.	Yes	No	No	No	No	NA
Medical officers of health at the local health units played a critical role as policy entrepreneurs.	No	Yes	Yes	Yes	Yes	Yes
At the provincial level, the activities of the policy entrepreneurs reflected the persistence and protracted ‘softening up’ process necessary to achieve change.	NA	NA	NA	NA	NA	Unclear
Key external political allies enabled PHUs to re-focus their scope of services to address the SDH	Yes	NA	No	Yes	Yes	NA
Key barriers in the political stream reflect tensions between the long-term nature of progress on the SDH vs. political demand to see short-term results.	No	No	No	No	No	No
Barriers in the political stream also include the fact that SDH-focused solutions are not revenue neutral, which limited their political saleability in a climate of fiscal restraint.	Partial support	NA	Partial support	Partial support	Partial support	Yes
The activities of the policy entrepreneurs may have reflected a protracted process of bargaining and trade-offs from ideal positions in order to gain wider support.	No	NA	No	No	No	Unclear
Barriers in the policy stream limited the reach and impact of the local level initiatives.	Yes	Yes	Yes	Yes	Yes	NA
Implementation of SDH-focused initiatives at some of the local public health units resulted from a “partial coupling”, a convergence of two streams (problem and politics).	Yes	Yes	Yes	Yes	Yes	NA
A full coupling at the provincial level may not have been achieved due to barriers in any one of the three streams.	NA	NA	NA	NA	NA	Yes

9.2 Key factors outside of multiple streams theory affecting SDH policy initiation by Ontario health units

Geography

When considering possibly explanatory factors outside the realm of multiple streams theory, one of the key variables noted by respondents was geography. Specifically, geographic location and associated features (e.g., population density, proximity to other communities) was identified as both an enabling factor and a hindrance to SDH-focused initiatives by three of the five local health unit cases: Peterborough, Sudbury and Huron.

The geographic characteristics of the Peterborough health unit (PCCHU) catchment area, particularly its small size, relative isolation from the Greater Toronto area, and low population growth, was identified by multiple respondents as a key factor influencing PCCHU's efforts to take action on the SDH. One of the community champions interviewed for this study, a long-term Peterborough resident who chaired the Housing Committee on the Mayor's Action Committee on poverty, described the historical antecedents that shaped both Peterborough's growth and its SDH deficits.

“For many years the only way that you could get from Toronto to Ottawa was along Highway 7, which crossed through Peterborough. Once the 401 was built and went right through, then Peterborough became a little more separated....if you take a look at a map once you start moving north and east of Peterborough you start to see isolation and increased levels of poverty....it's something people don't think about until you show them the map and look at the demographics.”

Peterborough's small size and relative isolation also ensured a level of community cohesion that was conducive to collaboration on SDH issues. When describing community assets

supporting SDH actions, the current MOH of PCCHU noted that *“certainly this is a small, very cohesive community where people know one another. So there are strong relationships upon which to build.”* This view was shared by the Health Promoter, who described how the high level of cohesion among key community organizations helped to expedite the implementation of SDH initiatives: *“...we really do have close relationships with our community partners - very one-on-one relationships. And if somebody has an idea you just call up the ten people you know in the community who can make it happen and it happens.”*

Geography was also identified as an asset to SDH-focused action by the Sudbury and District Health Unit (SDHU). Like Peterborough, Sudbury is relatively isolated from other urban centres and serves as a regional hub for the surrounding area. Over the course of her interview, the SDHU Director speculated that the geographic features of Sudbury were conducive to the levels of community cohesion and inter-sectoral cooperation that fostered SDH-focused initiatives:

“In Sudbury there is a history of people working together. I don’t know if it’s because it’s a northern community or if it’s the size of the community...but I do know that people from Sudbury stakeholder organizations tend to believe that we work well and effectively in coalitions. For the most part, that’s true.”

Conversely, geography posed a barrier to SDH-focused action by the Huron County Health Unit (HCHU). The geographic features of the HCHU catchment area, a predominantly rural county with a dispersed population and no large urban ‘hub’, appears to have impacted upon HCHU’s attempt to integrate the SDH into its scope of practice in two ways. First, it limited the amount of SDH-focused community engagement and intersectoral collaboration that could realistically be achieved by a small health unit with limited staff and resources. Second,

the ability of HCHU to plan and implement SDH-focused initiatives was constrained by provincial funding criteria that were more relevant to the needs of larger, more urban health units (Henning, 2016; Nelligan, 2016).

Community Culture

A community culture that was favourably predisposed to health unit action on the SDH was cited by three of the five local cases: Peterborough, Sudbury and Waterloo Region. Although the social, cultural, economic and political aspects of these communities vary, each, in their own unique way, offered an environment that was conducive to health unit action on the SDH.

In Peterborough, the health unit operated in a community with a long history of organizing around key SDH issues such as housing, poverty and food security. The historically high levels of poverty in much of PCCHU's catchment area inspired a dedicated coalition of organizations and individuals with a strong commitment to social justice and improving the quality of life for marginalized community members. In describing this phenomenon, one community member noted that organizing around SDH issues *"just emerged as a way to do things. And the other part of this story is the willing engagement of this community to get involved in making it a better place to live."*

Sudbury, with its mineral resources and its role as a regional hub for government, education, health care and retail services, can be characterized as a wealthier community than the catchment area served by the Peterborough health unit. But Sudbury also possessed some unique community characteristics that favoured health unit activities addressing the SDH. These include a strong organized labour presence and a left-leaning political culture that, until fairly recently,

elected NDP candidates at the federal and provincial level. As was noted previously, the SDHU Director speculated that SDHU's ability to integrate the SDH into its scope of practice was, in part, attributable to *"a 'left to middle-leaning community' in terms of the way that it's voted in the past...I don't know if it could be the case - but with the strong labour focus in our community, with Inco and Falconbridge combined with the 'left to middle' leaning community, I have wondered whether or not that has shaped the way that our Board [of Health] or the community in general thinks about these issues."*

Like their counterparts in Peterborough, the MOH and staff at SDHU also benefitted from a small but dedicated cadre of community organizations that were committed to ensuring more equitable access to food, housing, income and employment opportunities among Sudbury residents. In 2000, a new MOH, who made a deliberate effort to reach out to these groups, was welcomed as a trusted ally and advocate. The subsequent death of Kimberly Rogers and the MOH's active role in the Coroner's inquest served to strengthen ties between SDHU and key community allies, paving the way for subsequent collaboration on SDH-focused initiatives (Sutcliffe, 2015; Gasparini, 2016).

In the Region of Waterloo, the establishment of a dedicated Health Determinants Division within the health unit (RoWPH) was linked to the presence of a local community culture based on Mennonite values of altruism and mutual aid. As was noted previously, the RoWPH MOH, when describing the community conditions affecting the health unit's SDH-focused initiatives, observed that *"I think there is something to this Mennonite heritage as well...A very definite concern and a number of agencies that have a really strong belief in collective impact...you know, working together, helping others. So I think it [the Health*

Determinants Planning and Evaluation Division] *found a home in terms of the philosophy of a lot of its partners in the community.*”

RoWPH also benefitted from a long, positive history of collaboration with SDH-focused community groups that preceded the creation of its HDPED. There was initial concern that the creation of a new SDH-focused Division, with its broad and seemingly nebulous mandate, might serve to compromise the relationships with key community partners that RoWPH had taken years to build (Schumilas, 2015). However, RoWPH’s decision to focus its efforts on strengthening the SDH planning, evaluation and advocacy capacity of community groups met with a positive reception. As a former RoWPH Director noted, *“By and large community groups were on our side...they were our advocates.”*

Antecedent Events

As was noted previously, policy analysts have criticized the multiple streams theory for negating the impact of learning from experience in explaining policy shifts (Sabatier, 1988; Weir, 1992; Hall, 1993). While Kingdon (2011) acknowledges the role of antecedent conditions in shaping policy options, multiple streams theory tends to treat each opening of a ‘policy window’ as a discrete event. While this may be a necessary prerequisite for individual case analysis, it overlooks the fact that the policy positions of key actors (policy entrepreneurs and decision makers alike) are shaped by their experience with previous attempts to change policy.

For the purposes of this study, antecedent events are not limited to previous efforts to change SDH-related policies: they also refer to preceding events in the community that shaped the discourse around policy options. Antecedent events should not be confused with Kingdon’s notion of focusing events that may directly precipitate greater attention towards a policy issue.

Rather, antecedent events impact collective learning regarding a policy issue, which, in turn, helps to define both the nature of a problem and the range of available policy options to address it.

At the local health unit level, the study found two possible instances of influential antecedent events, both of which are discussed in the individual case summaries. In Peterborough, the Harris-era rescinding of provincial approval to establish the first community health centre in the city/county may have placed increased community expectations on PCCHU to fill the void of SDH-specific community engagement, intersectoral collaboration and advocacy - roles that are often performed by CHCs (Favreau, 2015). In Waterloo Region, the 1995 approval of a Community Safety and Crime Prevention Council, which took an upstream, SDH-focused approach to preventing the root causes of crime, set a precedent that may have expedited the subsequent establishment of the RoWPH's Health Determinants Planning and Evaluation Division (Nolan, 2016).

Contribution of Other Policy Change Models: The Advocacy Coalition Framework and the Punctuated Equilibrium Theory

While the multiple streams theory has demonstrated utility in analyzing the factors affecting the initiation of early SDH-focused public health initiatives at the local and provincial level, the explanatory role of other policy change models should not be overlooked. Two models that provide insightful alternate explanations to the policy change processes examined in this study are the advocacy coalition framework (Sabatier, 1988; Sabatier and Jenkins Smith, 1993) and the punctuated equilibrium framework (Baumgartner and Jones, 1993).

The advocacy coalition framework was conceived in the late 1980s in response to what its creators viewed as key limitations to existing policy change theories. These include the

limited predictive ability of linear, stage-based heuristics (e.g., identify problem, develop possible solutions....), the need for more systems-based approaches to the study of policy making, and the lack of theory and research on the role of scientific and technical information in guiding policy decisions (Weible, Sabatier and McQueen, 2009). The advocacy coalition framework maintains that policy results from a broad ‘subsystem’ of key actors working together as a coalition. These actors include, but are not limited to, interest groups, researchers, the media and sympathetic government officials (Sabatier and Jenkins Smith, 1993).

These coalitions for policy change are formed and sustained through a set of shared core beliefs. The advocacy coalition framework proposes a three-tiered belief system for actors in a policy change coalition: **deep core beliefs**, the broadest and most stable normative beliefs (e.g., socialist versus neoliberal); **policy core beliefs**, which are of moderate scope and span the breadth of the policy subsystem; and **secondary beliefs**, which are more empirically based and substantively narrow in scope. Of these, shared policy core beliefs are the key determinant of forming coalitions and coordinating activities focused on policy change (Weible, Sabatier and McQueen, 2009). The maintenance of shared beliefs and optimal relations among coalition members over time is critical for successful policy implementation (Sabatier, 1988).

The advocacy coalition framework identifies four paths to policy change in a policy subsystem. The first path, which is somewhat akin to Kingdon’s concept of focusing events, is **external subsystem events**. These are defined as external events or shocks, such as rapidly deteriorating economic conditions, bringing about a change in policy-related beliefs. The second path to change is **policy-oriented learning**, alterations in beliefs or intentions resulting from experience and/or new information pertaining to policy objectives. The third path to change is **internal subsystem events**, which occur within a sub-system and surface failures of current

subsystem practices. The fourth and final path, which is premised on alternate dispute resolution studies, occurs through negotiated agreements involving two or more coalitions (Weible, Sabatier and McQueen, 2009).

The advocacy coalition framework may have some applicability in analyzing the two local cases where SDH-related public health initiatives were primarily planned and implemented through coalitions of public health staff and community organizations: Peterborough and Leeds-Grenville-Lanark. As the local case summaries illustrate, the key actors in both Peterborough and Leeds-Grenville-Lanark shared the **policy core beliefs** on the need for greater SDH-focused action in their respective communities. In Peterborough, shared beliefs between community organizations and sympathetic public health staff precipitated a shift towards a greater focus on the SDH by PCCHU (McKeen, 2015; Post, 2015). But this shift followed a period of dialogue where community members identified the limits of PCCHU's scope of practice or, in the parlance of advocacy coalition framework vocabulary, its **internal subsystem**. In Leeds-Grenville-Lanark, the MOH formed a broad coalition of community agencies with common policy core beliefs around the importance of intersectoral collaboration and collective advocacy for addressing the SDH. The creation of the LGL Health Forum was also prompted by an event in the **external subsystem**, the release of discouraging local health status data which captured the attention of community service providers (Gardner, 2015; Marshall, 2015).

While the advocacy coalition framework provides an alternate paradigm for assessing at least two of the local cases, it should be noted that one of the assumptions of the theory is that a time period of ten years or more is needed to clearly understand a policy change event (Sabatier and Jenkins-Smith, 1993). Since this time period exceeds the time-frame of this study (January

2000-January 2009), further research is needed for a more fulsome application of the advocacy coalition framework to analyze the development of SDH-focused public health initiatives.

Punctuated equilibrium theory, the second alternate policy change model under consideration, maintains that long periods of policy continuity are ‘punctuated’ by periods of instability and rapid change (Baumgartner and Jones, 1993, 2009; Cairney, 2012). Like the multiple streams theory, the punctuated equilibrium theory is premised on the notion that, due to finite attention and resources, only a small number of policy problems rise to the top of the political agenda (True et al, 2007). The theory argues that incremental change in most cases is accompanied by a more seismic change in a small number of cases, with both outcomes resulting from the ‘disruptive dynamics’ that characterize how political systems process information (Baumgartner and Jones, 2009).

At a macro level, punctuated equilibrium theory may shed some light on the policy dynamics underlying efforts to establish SDH-specific public health standards over the course of *Operation Health Protection*. Following a long period of policy continuity, during which the scope of mandated public health unit functions and services remained unchanged, the ‘disruptive dynamics’ of Walkerton and SARs led to the initiation of *Operation Health Protection*, which provided an opportunity to revisit all aspects of public health practice, including SDH-focused work. Concurrently, both incremental and more ‘seismic’ shifts in SDH-focused practice among early adopter health units led to a coalition of actors with specific policy solutions to address the SDH at a provincial level.

9.3 Implications for research, policy and practice

9.31 Implications for Research

The present study represents an attempt to systematically apply the key constructs of multiple streams theory (MST) in order to better understand the emergence of SDH-focused public health practice by Ontario health units. As such, it typifies both the strengths and challenge of utilizing MST as a framework for analyzing policy decisions.

As was noted previously, one of the key strengths of the MST is the abundance of documented applications: a meta-review by Jones et al (2016) identified at least 311 peer reviewed articles testing MST concepts published from 2000 to 2013. However, only one third of these applications focused on all three streams and even fewer assessed key subcomponents of these streams (e.g., feedback, focusing events and indicators within the problem stream). In addition, these applications provide rudimentary (at best) definitions of MST concepts, a key limitation given that Kingdon's articulation of the MST presents the concepts as both inter-related and necessary for a fulsome explanation of the policy agenda setting process (Jones et al., 2016).

While the present study incorporated all of the three streams and their related constructs (within the parameters of the data available), the lack of comprehensive, standardized applications of the MST limits comparisons between the results of the present study and studies applying MST to assess the adoption of SDH-related policies in other settings (both within and outside of the public health sector) and jurisdictions. This, in turn, undermines the capacity of the MST to yield generalizable knowledge about the policy-making process. In their summation of the methodological flaws inherent in studies applying the MST, Weible and Schlager (2016, pp.

8-9) note that *“its strength is its weakness...the MSA [multiple streams approach] offers a set of concepts that can be selectively applied to virtually every policymaking setting with a multiplicity of methodologies but this portability and flexibility simultaneously compromises its capacity to generate knowledge about the policy process....the conditions characterizing the MSA are becoming just as ambiguous as the phenomena it was designed to study.”*

To rectify this deficit, Jones et al (2016) call for a more rigorous operationalization of MST core concepts across applications to facilitate the theoretical development of the model. The authors also call upon policy researchers to focus greater attention towards the issues of scope and attributes to better determine what predictive limitations of MST exist and under what conditions.

A greater diversity of research methodology is also needed to fully harness the predictive potential of the MST. To date, applications of the MST rely primarily on qualitative case study designs (Cairney and Heikkila, 2014; Jones et al., 2016). But a smaller number of studies utilize sophisticated quantitative methods, ranging from ordinary least squares regression analysis to simulation models (Jones et al., 2016). Given the inherent value of quantitative and qualitative research designs, the application of both approaches, as well as mixed methods, are required to develop and test MST-related hypotheses.

Productive lines of research may be realized by extending the duration of MST applications. The present study demonstrates how the MST can be expanded beyond the policy agenda setting stage to encompass policy implementation as well as termination. Expanding the focus of MST to policy implementation is logical given that policy processes are non-linear and factors in the three streams affecting agenda setting and adoption may subsequently impact the implementation stage (Weible and Schlager, 2016; Zahariadis and Exadaktylos, 2016).

Moreover, as the HCHU case illustrates, changes in one of the three streams between adoption and implementation (i.e., an erosion in political support) can nullify previous success with getting issues on policy agendas.

To advance local-level actions on the SDH, the public health sector in Ontario (and elsewhere) would benefit from MST applications that are oriented towards the perspective of the ‘practitioner-advocate’, a term characterizing the role of the ‘policy entrepreneurs’ championing SDH initiatives in the local and provincial cases. However, only a small proportion of MST applications to date fall into this category (Cairney and Jones, 2016; Jones et al., 2016). In recent years, a growing number of practitioner-focused MST studies have sought to identify pragmatic implications for policy agenda setting without a detailed focus on theory (Cairney, 2015). It is hoped that this trend will yield useful lessons for the public health sector to advance SDH-focused policies.

Further research is also needed on the factors shaping SDH-related opinions and attitudes among the two key constituencies whose support is essential for SDH-focused public health initiatives: elected decision makers and the general public. Surprisingly little is known about how (or if) elected officials view the impact of their policy positions on the SDH. Further research in this area has the potential to provide useful insight into how elected representatives can integrate the SDH into their policy platforms and activities (Raphael, 2015).

The results of the present study indicate that an engaged, dedicated coalition of community activists or community organizations was a key factor in getting the SDH on the agenda of local PHUs. However, in the absence of local grassroots support, which was evident in four of the five local cases (excepting HCHU), the success of SDH-focused community engagement was contingent upon the ability to raise public awareness of the SDH and their

impact upon health. Limited research to date suggests a deficit of knowledge regarding the significance of the SDH in shaping the health of Ontarians. For example, Shankardass et al (2012) conducted a telephone survey of over 2,000 Ontario adults to assess awareness of income-related health inequalities. While 73% of respondents concurred with the general premise that not all Ontarians are equally healthy, fewer were aware of inequities in health outcomes between the rich and poor (53%-64% depending on the framing of the question). Public awareness of income-related inequities for specific health outcomes was even lower, ranging from 18% for accidents to 35% for obesity (Shankardass et al., 2012).

This awareness deficit may be attributable to a number of factors, including the tendency of liberal welfare-state populations to equate health status with access to health care and personal responsibility (Langille, 2009; Coburn, 2010), and a media that often portrays the SDH as issues that only affect disadvantaged groups (Lucyk, 2016). Further research on the factors shaping public understanding of the SDH is needed to guide the development of effective communication strategies that will increase public demand for government action on the SDH (Shankardass et al., 2012; Raphael, 2015).

Last, and arguably of greatest importance, a concerted program of research is required to expand the evidence base for effective local public health interventions addressing the SDH. Considerable progress was made over the duration of this study (2000-2009), including SDHU's ten promising practices (SDHU, 2011). In subsequent years, the adoption of more sophisticated planning and needs assessment tools by Ontario PHUs, including health equity impact assessment (HEIA) templates and GIS mapping, have ensured that evidence plays a more predominant role in informing community level initiatives addressing the SDH (NCCDH, 2015a). Moreover, the creation of Public Health Ontario (PHO) in 2008, a provincial crown

agency with a mandate to “*enable informed decisions and actions that protect and promote health and contribute to reducing health inequities,*” (PHO, 2016), has provided Ontario health units with access to equity and SDH-focused training and technical support that was not available during the period covered by the present study.

But in spite of these advances, successive environmental scans and surveys of key informants indicate that a dearth of applied research on equity and SDH-focused public health interventions remains a key deficit (OPHA-aLPHa, 2010, NCCDH, 2011; NCCDH, 2014). Building the knowledge base for effective practice should not be the exclusive domain of local PHUs: rather it requires a system-level approach, with strategic coordination and partnerships between PHUs, PHO, the National Collaborating Centre on the Determinants of Health (NCCDH) and university-affiliated researchers. One MOH, supporting the need for these partnerships, noted that “*this work is bigger than any one local public health unit. It’s a system, and we need to be working collectively with researchers and our provincial agencies.*”

9.32 Implications for Public Health Policy and Practice

The study identified a number of practical strategies for integrating the SDH into the policy agenda of PHUs and securing the necessary support and resources for SDH work. These include:

- the use of key community and political allies as ‘champions’ to secure support;
- concerted outreach and engagement with existing community coalitions and potential community partners to identify mutually shared SDH priorities;
- an incremental approach to institutionalizing SDH practice that utilizes small, low-cost ‘wins’ (e.g., supportive BOH resolutions, in-house SDH coordinating committees) as the basis for expanding actions over time;

- persistent information sharing, outreach and education with key stakeholders (i.e., BOH members, local elected officials) to ‘normalize’ SDH initiatives as part of routine public health practice;
- leveraging key community-level or provincial developments (i.e., focusing events) to initiate or advance SDH-focused public health practice.

These implications for policy agenda setting do not represent innovations in public health practice. Rather, they re-affirm the utility of earlier strategies and tactics used to secure advances in other public health priorities such as comprehensive tobacco control (Beaglehole, 1991; McKinlay and Marceau, 2000).

A more critical issue for SDH-focused public health practice concerns policy implementation rather than policy agenda setting. As was noted previously, four of the five local health units in this study invested heavily in building organizational capacity for SDH-focused action. In the ensuing years, as more public health organizations made concerted efforts to address health equity and the SDH, organizational capacity was consistently identified as a deficit in surveys of key stakeholders (OPHA-alpha, 2010; NCCDH, 2011, 2014). A key informant interviewed for the most recent NCCDH environmental scan (in 2014) made what may be construed as a direct reference to some of the health units in this study by observing that *“recent advancements in capacity may have taken greatest hold within organizations that were previously committed, well resourced, and actively engaged in health equity action.”* (NCCDH, 2014, p. 19).

The experience of the early adopter PHUs in Ontario is evident in a proposed organizational capacity for public health equity action (OC-PHEA) framework created by Cohen et al (2013). Developed through a series of key informant interviews with “health equity champions” and a literature review of existing concepts/frameworks related to the organizational

capacity of the public health system, the OC-PHEA framework delineates two key domains of organizational capacity for effective public health action to reduce health inequities: 1) internal context, organizational dimensions affecting its capacity to act, and 2) an enabling external environment encompassing dimensions of the communities and broader systems affecting the ability of public health organizations to act. Both domains share similar dimensions, including common values (e.g., shared societal responsibility for equitable opportunities for health), commitment and will and a supportive infrastructure (Cohen et al., 2013).

The “early adopter” leaders in Ontario and other regions of Canada are well positioned to assume mentorship roles for public health organizations in more developmental stages of building capacity for SDH and equity-focused action (NCCDH, 2014). More concerted engagement of these leaders through networks, tailored outreach and resources documenting their experiences is needed to “level-up” what is currently perceived as a highly variable level of capacity for SDH-focused action across the public health sector (Cohen et al., 2013; NCCDH, 2014).

Early adopter health units also have the potential to offer insights for addressing persistent constraints to SDH-focused action. These include, but are not restricted to: reaching consensus and understanding around key terminology; overcoming low levels of support by senior leadership; delineating appropriate boundaries between the SDH-focused work of the public health sector and sectors with more direct responsibility for the SDH (e.g., transportation, housing); establishing shared priorities with key partners; and measuring impact (NCCDH, 2014; 2015a). While the early champions of SDH-focused public health practice interviewed for this study did not meet with unqualified success in dealing with these barriers, their mentorship with

public health organizations at more nascent stages of developing SDH actions might aid in the identification of viable, system-level solutions over time.

Special attention needs to be focused on the barriers to public health advocacy as a strategy for redressing health inequities and ensuring more equitable access to the SDH. With its extensive knowledge of the SDH and their attendant impacts on population health, the public health sector is uniquely situated to assume a lead role in advocating for multi-sectoral policy solutions to reduce health inequities. While the majority of the local health units (4/5) in the present study either engaged in direct advocacy (PCCHU and SDHU), advocacy through participation in broader community coalitions (LGLDHU) or efforts to build the advocacy capacity of their community partners (RoWPH), their experiences may not be representative of the broader public health sector. A scoping review of published and grey literature by Cohen and Marshall (2016) found little evidence that SDH-focused advocacy was occurring in public health practice. The lack of equity and SDH-focused advocacy within the public health sector was linked to a range of barriers, including: an interpretation of advocacy practice as limited solely to lobbying; a lack of organizational capacity; a reticence to engage in advocacy to avoid politically-charged public controversy; and an interpretation of health premised on a biomedical perspective and individual responsibility for healthy lifestyles and behaviours congruent with neoliberal governance (Cohen and Marshall, 2016).

As was noted previously, the local health units in this study did encounter impediments to advocacy (although some of the health units appeared to be operating in organizational and political environments that imposed fewer constraints to advocacy than those that were present in other jurisdictions). The one obstacle that the health units appeared to avoid was the error of conflating advocacy with political lobbying. In situations where the direct engagement of

political decision makers on SDH issues was (or was perceived to be) contentious, health units reconceptualised their advocacy role to focus on more covert supports, including the provision of data, resources and capacity building to community organizations in a position to engage in direct advocacy unimpeded by bureaucratic and political constraints.

In the provincial case, there was evidence that discomfort with the optics of funding PHUs to lobby against government policies led to the omission of the term ‘advocacy’ in the *Ontario Public Health Standards*. However, as was noted previously by one of the MOH champions of the failed SDH standards, the absence of prescriptive advocacy directives in the OPHS gave health units added flexibility to respond to SDH issues: “*so it may be that this is deliberate. That by not being prescriptive, it [The Foundational Standard] provides the opportunity for some boards of health to be much stronger advocates because they’re not being restricted.*” The uncertainty around the parameters of PHU advocacy persists, and it remains to be seen whether or not the ongoing modernization of the OPHS, announced in late 2015 (OMHLTC, 2015), will address this issue. In the interim, PHUs committed to action on the SDH continue to navigate advocacy initiatives within the enablers and constraints of their organizational structures and the broader political environment.

10. Epilogue: Key Developments since 2009

“I ran out of food this weekend...I am unable to sleep.”

Excerpt from Kimberly Roger’s appeal to Ontario Superior Court of Justice, May 2001.

“I wish we could get beyond talking about free transit passes.”

Comment by SDH nurse at health equity impact assessment workshop, Toronto, 2015.

On January 1, 2009, the Ontario Public Health Standards (OPHS) went into effect. For the first time, Ontario’s 36 health units had standard requirements to reduce health inequities through the planning and delivery of focused interventions to meet the needs of priority populations.

Over time, the shift towards a more uniform approach to addressing health equity and the SDH meant that many of the SDH-focused organizational entities created by the early adopter health units were superseded by structural arrangements that more directly enabled the fulfilment of the requirements stipulated in the OPHS Foundational Standard. In 2010, the Health Determinants Planning and Evaluation Division at RoWPH ceased operation, and resources were re-directed towards supporting Foundational Standards requirements. (Seskar-Hencic, 2015). PCCHU abandoned its SDH committee in 2012 in favour of a Foundational Standards team supporting the integration of SDH and equity considerations into every health unit program (Post, 2015). In 2014, SDHU replaced its Health Equity Committee with a more broadly constituted Health Equity Knowledge Exchange and Resource Team (HEKERT), an interdisciplinary, inter-divisional group supporting the entire health unit (NCCDH, 2015a).

Health units also had to adjust the nature and scope of their SDH-focused programs in response to new provincial directives as well as new resources. In 2011, the equity-focused planning requirements of Ontario’s health units were strengthened by the introduction of the

Ontario Public Health Organizational Standards (MOHLTC, 2011), which specified the management and governance requirements for all Boards of Health. Section 3 of the Standards, “Leadership”, requires BOHs to carry out a process of strategic direction setting through a strategic plan that includes a description of *“how equity issues will be addressed in the delivery and outcomes of programs and services”* (MOHLTC, 2011, p. 14).

A substantive infusion of staff capacity to address the SDH occurred in 2012, when the Public Health Division of the MOHLTC was able to secure funding for each of Ontario’s 36 PHUs to hire two full-time equivalent public health nurse (PHN) positions (a total of 72 nurses provincially) to focus exclusively on SDH initiatives. The intent of these positions was to enhance program and service supports to specific priority populations most negatively impacted by the determinants of health (Peroff-Johnston and Chan, 2012).

A 2015 case study on the implementation of the SDH PHN positions conducted by the National Collaborating Centre on the Determinants of Health surfaced many of the same themes and issues identified in the present study. These included: underlying philosophical tensions between biomedical/behavioural public health practice and addressing the social conditions affecting health; limited evidence and competencies to guide SDH-focused public health practice; embedding SDH and equity considerations into all aspects of health unit work; and the challenges and benefits of collaborating with a broad array of community partners. Not surprisingly, health units with a tradition of planning and implementing SDH-focused initiatives seemed better equipped to strategically position the SDH PHNs within their respective organizational structures and utilize their skills; by contrast, SDH PHNs employed at health units that were less advanced in SDH-focused practice were more likely to encounter limited guidance and a lack of role clarity as barriers to action (NCCDH, 2015b).

By the late 2000s, the proliferation of social media outlets, including Facebook, YouTube, and Twitter, provided public health units with additional venues for addressing what had proven to be a perennial challenge: raising community awareness of the SDH. Ontario's public health units were relative late-comers to the social media arena. Davies et al (2014) note that the first health units used social media outlets in 2008-2009 to issue communiques about the H1N1 pandemic.

Once this precedent had been set, health units began to explore ways of leveraging social media to communicate about other aspects of their mandate. In 2011, SDHU released *Let's Start a Conversation about Health...and Not Talk About Health Care At All*, a short video using plain language to discuss the SDH and their impact on community health status. This video was posted on YouTube and has been adapted for local use by 14 other PHUs in Ontario (Raphael, Brassolato and Baldeo, 2014). But the challenge of capturing public attention in an ever-expanding plethora of social media outlets ensures that raising awareness of the SDH remains a daunting task. One community advocate made the following observation about the SDH informational video produced by her local PHU: *"You probably saw the video clip the health unit did. I mean God that was brilliant! But I couldn't get people to watch that. I couldn't get people to talk about that...it blew my mind."* An MOH concluded a description of her health unit's recent (post 2009) efforts to raise community awareness of the SDH by noting that *"we have a long, long way to go there. There's no doubt."*

Other challenges appear to be as salient as they were at the onset of the cases described in this study. A 2015 case study analysis of contemporary SDH activities by four Ontario health units commissioned by the NCCDH concludes with a list of 'potential tensions' that would strike a familiar chord with the early adopters initiating SDH-focused work in the early-mid 2000s.

These include: building a shared vision and understanding among health unit staff; achieving the optimal balance between targeted and population level approaches; ‘normalizing’ SDH initiatives as part of routine health unit business; and taking meaningful action on the SDH (with their broader social and political implications) within the prescribed mandate of PHUs (NCCDH, 2015a).

Yet the fact that PHUs are grappling with these challenges is a testament to the greatest achievement of ‘early adopter’ health units described in this study. During a time characterized by the explicit absence of SDH-related directives for PHUs, a dearth of resources for SDH-focused work and a neoliberal political climate that discouraged discussion of the SDH (let alone remedial action), these health units, with the support of key political and community allies, demonstrated that the public health sector could make practical contributions to addressing the SDH at a community level. In so doing, they helped to legitimize the SDH as a public health priority and lobbied to embed health equity and SDH considerations in the provincial blueprint for public health practice. One of the MOHs who played a key role in bringing this about provided the following summary of their achievements:

“Our mutual expectations of the work that we do have evolved, so that if one of us talks about the determinants of health at a meeting, it’s no longer automatically dismissed as ‘we should be talking about immunization!’ It’s part of the work we’re supposed to do now.”

As support for SDH-focused public health work continues to build, further research is needed to better elucidate the factors that enable and inhibit the emergence of SDH issues onto the policy agenda of PHUs. It is hoped that the insights gained from the present study will assist practitioners and policy makers in achieving a deeper understanding of how the adoption and implementation of SDH-focused initiatives are affected by contextual conditions, including the need to anticipate and account for these conditions in advocacy and planning processes. It is

further hoped that the study will serve as a basis for more fulsome applications of policy change theories to better understand and predict the conditions under which the public health sector can play a more proactive role in ensuring equitable access to the social and economic prerequisites for optimal health.

References

Anderson, L. (2006) "City Hall's new face." **Kawartha Lakes This Week**, November 14, 2006, 1.

Association of Local Public Health Agencies (2008) **Council of Medical Officers of Health Annual Report 2007-2008**. Toronto: aLPHa.

Association of Local Public Health Agencies (2010) History of Public Health Units in Ontario. Toronto: aLPHa

<http://www.alphaweb.org/?page=milestones> Retrieved on October 4, 2014.

Association of Local Public Health Agencies (2015) **2015 Orientation Manual for Boards of Health**. Toronto: aLPHa.

http://c.yimcdn.com/sites/www.alphaweb.org/resource/resmgr/boh_file/final_2015_orientation_manual.pdf Retrieved September 12, 2016.

Association of Local Public Health Agencies (2016) "Our members - who we are." Toronto:

aLPHa. http://www.alphaweb.org/?page=CopyofWho_we_are

Retrieved on October 6, 2016.

Association of Municipalities of Ontario (1999) **Local Services Realignment: A User's Guide**. Toronto : AMO.

Association of Municipalities of Ontario (2006a) **Closing the Gap: The Ontario Municipal Fiscal Situation Issues and Future Directions**. Pre-budget submission to the Standing Committee on Finance and Economic Affairs, February 2, 2006. Toronto, ON: AMO.

<https://www.amo.on.ca/AMO-PDFs/Reports/2006/2006ClosingtheGapOMPFPaper.aspx>

Retrieved on October 4, 2016.

Association of Municipalities of Ontario (2006b) **AMO's Response to the Final Report of the Capacity Review Committee: 'Revitalizing Ontario's Public Health Capacity.'** Toronto, ON: AMO.

<https://www.amo.on.ca/AMO-PDFs/Reports/2006/2006AMOResponsetoOntarioPublicHealthCapacityReview.aspx>

Retrieved on October 4, 2006.

Association of Ontario Health Centres (2016) **Community health centres**. Toronto: AOHC
<https://www.aohc.org/community-health-centres> Retrieved on September 12, 2016.

Badgley, R. (1978) **Health Promotion and Social Change in the Health of Canadians** Ottawa: Health and Welfare Canada.

Baumgartner, F., and Jones, B.D. (1993) **Agendas and Instability in American Politics** Chicago: University of Chicago Press.

Baumgartner, F., and Jones, B.D. (2009) **Agenda and Instability in American Politics** (2nd ed.) Chicago: University of Chicago Press.

Bazeley, P. (2007) **Qualitative Data Analysis with NVivo** Los Angeles: Sage.

Beaglehole, R. (1991) "Science, advocacy and health policy: lessons from the New Zealand tobacco wars." **Journal of Public Health Policy** **12** (2), 175-183.

Bennett, C.J., and Howlett, M. (1992) "The lessons of learning: reconciling theories of policy learning and policy change." **Policy Sciences** **25** (3), 275-294.

Berg, B.L. (1989) **Qualitative Research Methods for the Social Sciences** Boston: Allyn and Bacon.

Berkman, L.F., and Syme, S.L. (1979) "Social networks, host resistance and mortality: a nine-year follow-up study of Alameda County residents." **American Journal of Epidemiology** **109** (2), 186-204.

Black, D., Morris, J.N., Smith, C., and Townsend, P. (1980) **The Black Report** London: Department of Health and Social Security.

Blumer, H. (1954) "What's wrong with social theory?" **American Sociological Review** **18** (1), 3-10.

Bowen, G.A. (2006) "Grounded theory and sensitizing concepts." **International Journal of Qualitative Methods** **5** (3), 1-9.

Brunner, S. (2008) "Understanding policy change: Multiple streams and emissions trading in Germany." **Global Environmental Change** **18** (3), 501-507.

Burleton, D. (2007) **Greater Sudbury at a Crossroads**. Toronto: TD Bank Financial Group.
http://www.greatersudbury.ca/content/div_councilagendas/documents/Priorities%20-%20Economic.pdf Retrieved on September 16, 2016.

Cairney, P. (2007) “A multiple lens approach to policy change: the case of tobacco policy in the UK.” **British Politics 2** (1), 45-68.

Cairney, P. (2012) **Understanding Public Policy**. Basingstoke, UK: Palgrave.

Cairney, P. (2015) **The Science of Policymaking**. London: Palgrave Pivot.

Cairney, P., and Heikkila, T. (2014) “A comparison of theories of the policy process.” In P. Sabatier and C. Weible (Eds) **Theories of the Policy Process**. Boulder, CO: Westview Press, 363-390.

Cairney, P., and Jones, M.D. (2016) “Kingdon’s multiple streams approach: what is the empirical impact of this universal theory?” **The Policy Studies Journal 44** (1), 37-58.

Campaign 2000 (1999) **1999 Ontario Report Card**. Toronto: Campaign 2000.

Campbell, A. (2004) **The SARS Commission interim report: SARS and public health in Ontario**. Toronto: Queen’s Printer for Ontario.

Canadian Auto Workers Union (2008) **Fighting For Canadian Jobs: Manufacturing Matters Fact Sheet**. Toronto: CAW.
<http://www.caw.ca/en/campaigns-issues-manufacturing-matters-manufacturing-jobs-fact-sheet-2008.htm> Retrieved on September 8, 2016.

Canadian Institute for Health Information (2005) **Select Highlights on Public Views of the Determinants of Health** Ottawa: Canadian Population Health Initiative.
https://secure.cihi.ca/free_products/CPHI_Public_Views_FINAL_e.pdf
Retrieved on September 30, 2014.

Canadian Public Health Association (2014) “Changing public health practice to reduce social inequities in health.” Ottawa: CPHA.
<http://www.cpha.ca/en/programs/social-determinants/frontlinehealth/stories/sudbury.aspx>
Retrieved on September 26, 2014.

Capacity Review Committee (2006) **Revitalizing Ontario’s Public Health Capacity: The Final Report of the Capacity Review Committee**. Toronto, ON: Queen’s Printer for Ontario.

[http://neltoolkit.rnao.ca/sites/default/files/1.Capacity_Review_Committee_Full_Report_2006%20\(1\).pdf](http://neltoolkit.rnao.ca/sites/default/files/1.Capacity_Review_Committee_Full_Report_2006%20(1).pdf) Retrieved on September 3, 2016.

Chapman, S. (2001) “Advocacy in public health: roles and challenges.” **International Journal of Epidemiology** 30 (6), 1226-1232.

Charmaz, K. (2003) “Grounded theory: objectivist and constructivist methods.” In N.K. Denzin and Y.S. Lincoln (Eds) **Strategies for Qualitative Inquiry** (second edition) Thousand Oaks, California, Sage, 249-291.

Cobb, R.W, and Elder, C.D. (1983) **Participation in American Democracy: the Dynamics of Agenda Building** Baltimore: Johns Hopkins Press.

Coburn, D. (2010) “Health and health care: a Political Economy Perspective.” In T. Bryant, D. Raphael and M. Rioux (Eds) **Staying Alive: Critical Perspectives on Illness, Health and Health Care** (2nd ed) Toronto: Canadian Scholars Press, 65-92.

Cohen, B.E. et al. (2013) “A conceptual framework of organizational capacity for public health equity action (OC-PHEA).” **Canadian Journal of Public Health** 104 (3), 262-266.

Cohen, B.E., and Marshall, S.G. (2017) “Does public health advocacy seek to redress health inequities? A scoping review.” **Health and Social Care in the Community** 25 (2), 309-328.

Collins, P., and Hayes, M. (2007) “Twenty years since Ottawa and Epp: researchers’ reflections on challenges, gains and future prospects for reducing health inequities in Canada.” **Health Promotion International** 22 (4), 337-345.

County of Peterborough (2016) **Greater Peterborough’s Vital Signs 2016**

http://www.cfgp.ca/downloads/CFGFP_VitalSigns_WEB.pdf Retrieved on August 21, 2016.

Corlett, S. (1988) “Synthesis of the major themes of three health strategy reports.” Unpublished paper prepared for the Premier’s Council on Health Strategy, Toronto.

Coryn, C.L., Lindsay, A., Noakes, C.D. et al. (2010) “A systematic review of theory-driven evaluation practice from 1990 to 2009.” **American Journal of Evaluation** 32 (2), 199-226.

Crawford, R. (1977) “You are dangerous to your health: the ideology and politics of victim blaming.” **International Journal of Health Services** 7 (4), 663-680.

Cresswell, J.W. (2013) **Qualitative Inquiry and Research Design: Choosing Among Five Approaches** (Third Edition) Thousand Oaks, California: Sage.

Crowe, S., Cresswell, K., Robertson, A. et al. (2011) “The case study approach.” **BMC Medical Research Methodology** **11**: 100.

Davies, J. et al. (2014) **Social Media Toolkit for Ontario Health Units**. Guelph, ON: Wellington-Dufferin Health Unit.
<http://everykid.on.ca/wp-content/uploads/2016/05/Social-toolkit-public-health-web-final.pdf>
Retrieved on October 12, 2016.

Deber, R. A. et al. (2006) “A cautionary tale of downloading public health in Ontario: what does it say about the need for national standards for more than doctors and hospitals?” **Health Care Policy** **2** (2), 60-75.

DeLeeuw, E. (1999) “Healthy cities: urban social entrepreneurship for health.” **Health Promotion International** **14** (3), 261-269.

Eckstein, H. (1975) “Case studies and theories in political science. In F. Greenstein and N. Polsby (Eds) **Handbook of Political Science (Volume 7)** Reading, MA: Addison-Wesley, 79-138.

Economic Growth Solutions (2002) **Leeds-Grenville Economic Development Strategic Plan Final Report**.
<http://www.leedsgrenville.com/en/invest/resources/LeedsGrenville-EconomicDevelopmentStrategy.pdf> Retrieved on August 26, 2016.

Elections Canada (2016) **37th General Election, November 27, 2000**.
<http://www.elections.ca/content.aspx?section=ele&document=index&dir=pas/37g&lang=e>
Retrieved on September 4, 2016.

Embrett, M.G., and Randall, G.E. (2014) “Social determinants of health and health equity policy research: exploring the use, misuse and nonuse of policy analysis theory.” **Social Science and Medicine** **108** (5), 144-155.

EndGadget (2009) “Ten years of BlackBerry.”
<https://www.engadget.com/2009/12/28/ten-years-of-blackberry/> Retrieved October 24, 2016.

Evans, R.G., Barer, M.L., and Marmor, T.R. (Eds, 1994) **Why Are Some People Healthy and Others Not? The Determinants of Health of Populations** New York: Aldine De Gruyter.

Exworthy, M. (2008) "Policy to tackle the social determinants of health: using conceptual models to understand the policy process." **Health Policy and Planning** **23** (5), 318-327.
Favreau, J. (2016) Key informant interview, January 26, 2016.

Federation of Northern Ontario Municipalities (2016) District of Manitoulin.
<http://www.fonom.org/district-manitoulin> Retrieved on September 14, 2016.

Food Bank of Waterloo Region (2016) **Hunger Count Archives 2000-2005**
http://www.thefoodbank.ca/en/news/Hunger_Count_Archives.asp
Retrieved on September 11, 2016.

Forrest, B. (2008) "Medical officer of health resigns after months of tension between health unit and county administration." **Seaforth-Huron Expositor** August 20, 2008, 1.

Gardner, C. (2015) Key informant interview, November 16, 2015.

Gardner, C., Arya, N., and McAllister, M.L. (2005) "Can a health unit take action on the determinants of health?" **Canadian Journal of Public Health** **96** (5), 374-380.

Gasparini, J. (2016) Key informant interview, February 3, 2016.

George, A.L, and Bennett, A. (2004) **Case Studies and Theory Development in the Social Sciences** Cambridge, MA: MIT Press.

Greater Sudbury (2016) Key Facts.
<https://www.greatersudbury.ca/living/about-greater-sudbury/key-facts/>
Retrieved September 14, 2016.

Green, A., and Troup, K. (1999) **The houses of history: A critical reader in twentieth century history and theory** New York, New York: New York University Press.

Green, L.W. (1974) "Toward cost-benefit evaluation of health education: some concepts, methods and principles." **Health Education Monographs** **2** (Suppl 1), 34-65.

Green, L.W. (2006) "Public health asks of systems science: to advance our evidence-based practice, can you help us get more practice-based evidence?" **American Journal of Public Health** **96**, 406-413.

Guldbrandsson, K., and Fossum, B. (2009) "An exploration of the theoretical concepts policy windows and policy entrepreneurs at the Swedish public health arena." *Health Promotion International* 24 (4), 434-444.

Hall, P. (1993) "Policy paradigms, social learning and the state: the case of economic policy making in Britain." *Comparative Politics* 25 (3), 275-296.

Hancock, T. (1997) "Healthy cities and communities: past, present and future." *National Civic Review* 86 (1), 11-21.

Hancock, T., and Duhl, L. (1986) **Healthy Cities: Promoting Health in the Urban Context**. Copenhagen, WHO Regional Office for Europe.

Hancock, T., Labonte, R., and Edwards, R. (1999) "Indicators that count! Measuring population health at the community level." *Canadian Journal of Public Health* 90 (Suppl 1), S22-26.

Henning, B. (2016) Key informant interview, January 15, 2016.

Henning, B., and Nelligan, P. (2005) "Huron County Health Unit: Creating Health Communities Together". Presentation at joint aLPHa-OPHA conference, November 17, 2005.

Herriott, R.E., and Firestone, W.A. (1983) "Multi-site qualitative policy research: optimizing description and generalizability." *Educational Researcher* 12 (2), 14-19.

Hubay, S. (2015) Key informant interview, November 24, 2015.

Hurl, L.F. (1984) "The Toronto Housing Company, 1912-1923: the pitfalls of painless philanthropy." *Canadian Historical Review* 65 (1), 28-53.

Huron Business Development Corporation (2010) **State of the Huron County Economy 2010: Towards Sustainable Economic Renewal**. Goderich, ON: HBDC-Avon Maitland District School Board.

<http://www.smallbusinesshuron.ca/whatsnew/State%20of%20the%20Huron%20County%20Economy%202010%20Final.pdf> Retrieved on September 12, 2016.

Huron County Health Unit (2002) **Building Bridges**. Clinton, ON: HCHU.

Huron County Health Unit (2004) **Trust Before Change Report**. Clinton, ON: HCHU.

Huron County Health Unit (2005) **The Determinants of Health**. (internal planning document). Clinton, ON: HCHU.

Huron County Health Unit (2006) **Strategic Plan 2004-2007**. Clinton, ON: HCHU.

Huron County Health Unit (2009) **Community Health Status Report 2009**, Clinton, ON: HCHU.

<http://www.huronhealthunit.ca/wp-content/uploads/2014/02/Community-Health-Status-Report-2009.pdf>

Retrieved on September 15, 2014.

Hurst, L. (2000) "She's one in a millennium" **Toronto Star** January 1, 2000, A1, A22.

Hyndman, B. (2007) "Health promotion in Ontario: survival through capacity building." In M. O'Neill, A. Pederson, S. Dupere, and I. Rootman (Eds) **Health Promotion in Canada: Critical Perspectives** (2nd edition). Toronto: Canadian Scholars' Press Inc., 181-184.

Institute for Competitiveness and Prosperity (2004) **ICAP Canadian Cluster Data**. Toronto: ICAP.

Jackson, M.C. (2003) **Systems Thinking: Creative Holism for Managers** Chicester, UK: John Wiley and Sons Ltd.

Jones, M.D. et al. (2016) "A river runs through it: multiple streams meta-review." **The Policy Studies Journal** **44** (1), 13-36.

Kingdon, J.W. (2011) **Agendas, Alternatives and Public Policies** (Updated second edition) London: Longman.

Kragh, H. (1989) **An Introduction to the Historiography of Science** Cambridge: Cambridge University Press.

Labonte R. (1994) "Death of a program, birth of a metaphor: the development of health promotion in Canada." In A. Pederson, M. O'Neill and I. Rootman (Eds.) **Health Promotion in Canada: Provincial, National and International Perspectives**. Toronto: W.B. Saunders Canada, 72-90.

Labonte, R. (1995) "Population health and health promotion: what do they have to say to each other?" **Canadian Journal of Public Health** **86** (3), 165-168.

Labonte, R., and Penfold, S. (1981) "Canadian perspectives in health promotion: a critique." **Health Education** **19** (3-4), 4-9.

Lacey, K. (2002) "Poverty bad for health, medical officer of health testifies." **Northern Life**, November 22, 2002, 1.

Lacle, S. (2015) Key informant interview, December 1, 2015.

Lalonde, M. (1974) **A New Perspective on the Health of Canadians** Ottawa: Information Canada.

Langille, D. (2009) "Follow the Money: How Business and Politics Shape our Health." In D. Raphael (Ed.) **Social Determinants of Health: Canadian Perspectives** (2nd ed). Toronto: Canadian Scholar's Press, 305-317.

Leeds, Grenville and Lanark District Health Unit (2000) **Community Health Status Report for Leeds, Grenville and Lanark**. Brockville, ON: LGLDHU.

Leeds, Grenville Lanark Health Forum (2001) **A Strategy for Health Improvement for Lanark, Leeds and Grenville**. Brockville, ON: LGL Health Forum.

Lefebvre, S., Warren, C., Lacle, S., and Sutcliffe, P. (2006) **A Framework to Integrate Social and Economic Determinants of Health into the Ontario Public Health Mandate: A Discussion Paper**. Sudbury: Sudbury and District Health Unit.

<http://opha.on.ca/getmedia/421a59c9-bb20-43b3-97c5-13805d8287d2/SDOH-FrameworkDiscussionPaper-March06.pdf.aspx?ext=.pdf>

Retrieved on September 16, 2014.

Levy, J.S. (2008) "Case studies: types, designs and logics of inference." **Conflict Management and Peace Science** 25 (1), 1-18.

Lijphart, A. (1971) "Comparative politics and the comparative method." **American Political Science Review** 65 (3), 682-693.

Lipson, J. G. (1994) "Ethical issues in ethnography." In J. M. Morse (Ed.) **Critical Issues in Qualitative Research Methods** Thousand Oaks, CA: Sage, 333-355.

Lohmann, S. (2008) "Rational choice and political science." In S.N. Durlauf and L.E. Blume (Eds) **The New Palgrave Dictionary of Economics** (Second edition, online) Basingstoke, UK: Palgrave Macmillan. http://www.dictionarofeconomics.com/article?id=pde2008_R000253

Retrieved on December 20, 2014.

Lucyk, K. (2016) “They are not my problem: a content and framing analysis of references to the social determinants of health within Canadian news media 1993-2014.” **Canadian Journal of Communication** 41 (4), 631-654.

Mabry, P.L., Marcus, S.E., Clark, P.I., Leischow, S.J., and Mendez, D. (2010) “Systems science: a revolution in public health policy research.” **American Journal of Public Health** 100, 1161-1163.

MacDougall, H. (1990) **Activists and Advocates: Toronto’s Health Department 1883-1983** Toronto and Oxford: Dundurn Press.

MacKeigan, M (2004) **Putting People First: Exploring the Sustainable Livelihoods Approach in Waterloo Region**. Cambridge, ON: YWCA of Cambridge/Cambridge Self-Help Food Bank.

MacKinnon, M., and Lacey, K. (2001) “Bleak House.” **The Globe and Mail**, August 18, 2001. F1.

Mackenbach, J. (1997) “Socioeconomic inequalities in morbidity and mortality in Western Europe.” **The Lancet** 349, 1655-1659.

Manson-Singer, S. (1994) “The Canadian Healthy Communities Project: Creating a Social Movement.” In A. Pederson, M. O’Neill and I. Rootman (Eds) **Health Promotion in Canada: Provincial, National and International Perspectives** Toronto: W.B. Saunders Canada, 107-122.

Marmot, M. G.; Rose, G.; Shipley, M.; Hamilton, P. J. (1978). “Employment grade and coronary heart disease in British civil servants”. **Journal of Epidemiology and Community Health** 32, 244–249.

Marmot, M. (2004) **Status Syndrome: How your social standing directly affects your health and life expectancy** London: Bloomsbury.

Marshall, R. (2015) Key informant interview, November 23, 2015.

Martyn, J. (2015) Key informant interview, November 25, 2015.

Maxwell, J.A. (2012) **A Realist Approach for Qualitative Research** Thousand Oaks, California: Sage.

McCracken, K. (2013) “Sudbury: the journey from moonscape to sustainably green.” **ActiveHistory.ca** <http://activehistory.ca/2013/06/11360/> Retrieved September 14, 2016.

McKeen, M, Key informant interview, December 1, 2015.

McKinlay, J., and Marceau, L.D. (2000) “Upstream healthy public policy: lessons from the battle of tobacco.” **International Journal of Health Services** 30 (1), 49-69.

Meyer, S., and Ward, P. (2014) “How to use social theory within and throughout qualitative research and healthcare contexts.” **Sociology Compass** 8 (5), 525-539.

Miedema, J.M., and Pigott, K. (2007) **A Healthy Community Food System Plan for Waterloo Region**. Waterloo, ON: Region of Waterloo Public Health.
http://chd.region.waterloo.on.ca/en/researchResourcesPublications/resources/FoodSystem_Plan.pdf Retrieved on September 10, 2016.

Mikkonen, J., and Raphael, D. (2010). **Social Determinants of Health: The Canadian Facts**. Toronto: York University School of Health Policy and Management.

Mucciaroni, G. (1992) “The garbage can model and the study of Canadian policy making: a critique.” **Polity** 24 (3), 459-482.

National Collaborating Centre for Determinants of Health (2011) **Integrating Social Determinants of Health and Health Equity into Canadian Public Health Practice**. Antigonish, Nova Scotia: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
http://nccdh.ca/images/uploads/comments/Environ_Report_EN_150604.pdf
Retrieved on November 21, 2016.

National Collaborating Centre for Determinants of Health (2014) **Boosting Momentum: Applying Knowledge to Advance Health Equity**. Antigonish, Nova Scotia: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
<http://nccdh.ca/resources/entry/boosting-momentum>
Retrieved on September 29, 2014.

National Collaborating Centre for Determinants of Health (2015a) **The Path Taken: Developing Organizational Capacity for Improving Health Equity in Four Ontario Health Units**. Antigonish, Nova Scotia: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.
<http://nccdh.ca/resources/entry/developing-organizational-capacity-for-improving-health-equity-in-four-onta> Retrieved on October 10, 2016.

National Collaborating Centre for Determinants of Health (2015b) **Learning to Work Differently: Implementing Ontario's Social Determinants of Health Public Health Nurse Initiative**. Antigonish, Nova Scotia: National Collaborating Centre for Determinants of Health, St. Francis Xavier University.

<http://nccdh.ca/resources/entry/learning-to-work-differently-implementing-ontarios-sdoh-public-health-nurse> Retrieved on October 2, 2016.

National Council of Welfare (1996) **Poverty Profile**. Ottawa: National Council of Welfare.

Nelligan, P. (2016) Key informant interview, January 15, 2016.

Nolan, L. (2016) Key informant interview, February 2, 2016.

O'Connor, D.R. (2002) **Report of the Walkerton Inquiry: The Events of May 2000 and Related Issues Part 1: A Summary**. Toronto: Ontario Ministry of the Attorney General.

http://www.archives.gov.on.ca/en/e_records/walkerton/report1/index.html#summary
Retrieved on September 30, 2016.

O'Neill, M. (2012) "The Ottawa Charter: a manifesto for the 'protestor'?" **Global Health Promotion** 19 (2), 3-5.

O'Neill, M., Pederson, A., and Rootman, I. (2000) "Health promotion in Canada: declining or transforming?" **Health Promotion International** 15 (2), 135-141.

Ontario Ministry of Finance (2000) **2000 Ontario Budget Papers: Balanced Budgets - Brighter Futures**. Toronto: Queen's Printer for Ontario.

Ontario Ministry of Health (1997) **Mandatory Health Programs and Services Guidelines**

Toronto: Queen's Printer for Ontario.

<http://www.ontla.on.ca/library/repository/mon/6000/10270964.pdf>

Retrieved on September 27, 2014.

Ontario Ministry of Health (1999) **Population Estimates Database and Mortality Database HELPS1 Y2K June 1999 release**. Toronto, ON: OMH.

Ontario Ministry of Health and Long-Term Care (2004) **Operation Health Protection An Action Plan to Prevent Threats to our Health and to Promote a Healthy Ontario**

Toronto: Queen's Printer for Ontario.

http://www.health.gov.on.ca/en/common/ministry/publications/reports/consumer_04/summ_healthprotection04.pdf

Retrieved on September 28, 2014.

Ontario Ministry of Health and Long-Term Care (2008a) **Ontario Public Health Standards**
Toronto: Queen's Printer for Ontario
http://www.health.gov.on.ca/en/pro/programs/publichealth/oph_standards/docs/ophs_2008.pdf
Retrieved on September 27, 2014.

Ontario Ministry of Health and long-Term Care (2008b) **Release of the Ontario Public Health Standards: Background Questions and Answers.** Toronto: OMHLTC.

Ontario Ministry of Health and Long-Term Care (2009) **Operation Health Protection: Key Accomplishments** Toronto, April 17, 2009 news release.
<http://news.ontario.ca/mohlrc/en/2009/04/operation-health-protection.html>
Retrieved on September 29, 2014.

Ontario Ministry of Health and Long Term Care (2011) **Ontario Public Health Organizational Standards.** Toronto: Queen's Printer for Ontario.
http://www.health.gov.on.ca/en/pro/programs/publichealth/orgstandards/docs/org_stds.pdf
Retrieved on October 2, 2016.

Ontario Ministry of Health and Long-Term Care (2015) Communication to Board of Health Chairs and Medical Officers of Health re. OPHS modernization.
https://www.wdgpUBLICHEALTH.ca/sites/default/files/wdgpHfiles/Dr_%20Eric%20Hoskins,%20Minister,%20MOHLTC,%20Letter%20re%20Modernization%20of%20the%20OPHS.pdf
Retrieved on November 23, 2016.

Ontario Ministry of Public Safety and Security (2002) **Verdict of the Coroner's Jury Into the Death of Kimberly Ann Rogers 19 December 2002.** Toronto, ON: Office of the Chief Coroner.

Ontario Public Health Association-Association of Local Public Health Agencies (2010) **Activities to Address the Social Determinants of Health in Ontario Local Public Health Units. Summary Report.** Toronto: OPHA-aLPHa.

Ostrom, E. (1990) **Governing the Commons: The Evolution of Institutions for Collective Action** New York: Cambridge University.

Ostry, A.S. (1995) "Differences in the history of public health in nineteenth century Canada and Britain." **Canadian Journal of Public Health** 86 (1), 5-6.

Ostry, A.S. (2006) **Nutrition Policy in Canada, 1870-1939** Vancouver: UBC Press.

Pederson, A., and Signal, L. (1994) “The health promotion movement in Ontario: mobilizing to broaden the definition of health.” In A. Pederson, M. O’Neill and I. Rootman (Eds.) **Health Promotion in Canada: Provincial, National and International Perspectives**. Toronto: W.B. Saunders Canada, 244-261.

Pellizzari, R. Personal communication, September 8, 2014.

Peroff-Johnston, N., and Chan, I. (2012) **Evaluation of the Social Determinants of Health Nursing Initiative among Health Units in Ontario** (presentation). Toronto: Ontario Ministry of Health and Long-Term Care.

Peterborough City-County Health Unit (2005) **2005 Annual Report**. Peterborough, ON: PCCHU.

Peterborough City-County Health Unit (2006) **Ending Poverty Improves Health: Operational Plan 2006-07** Peterborough, ON: PCCHU.

Peterborough City-County Health Unit (2007) **Food Security Partnership Project: An Overview of 2006-2007 Activities and Recommendations for Continuation**. Peterborough, ON: PCCHU.

Peterborough City-County Health Unit (2012) **History and Highlights of Initiatives Addressing the Social Determinants of Health** Peterborough, ON: PCCHU.

Petticrew, M.M., Whitehead, S.J., MacIntyre, H. et al. (2004) “Evidence for public health policy on inequalities I: the reality according to policymakers.” **Journal of Epidemiology and Community Health** **58** (10), 811-816.

Pickens, B. (2015) Key informant interview, November 30, 2015.

Pinder, L. (1994) “The federal role in health promotion: art of the possible.” In A. Pederson, M. O’Neill and I. Rootman (Eds.) **Health Promotion in Canada: Provincial, National and International Perspectives**. Toronto: W.B. Saunders Canada, 92-106.

Post, C. Key informant interview, November 13, 2015.

Progressive Conservative Party of Ontario (1994) **The Common Sense Revolution**. Toronto, ON.

Public Health Ontario (2016) “Vision, mission, mandate and values.” Toronto: PHO. <https://www.publichealthontario.ca/en/About/Pages/Mission-Vision-and-Values.aspx>
Retrieved on November 21, 2016.

Rachlis, M., and Kushner, C. (1994) **Strong Medicine: How to Save Canada's Health Care System** Toronto: Harper-Collins.

Raphael, D. (2001) "Letter from Canada: paradigms, politics and principles: an end of the millennium update from the birthplace of the Healthy Cities movement." **Health Promotion International** 16 (1), 99-101.

Raphael, D. (2003) "Barriers to addressing the societal determinants of health: public health units and poverty in Ontario, Canada." **Health Promotion International** 18 (4), 397-405.

Raphael, D. (2012) "Canadian experiences." In D Raphael (Ed) **Tackling Health Inequalities: Lessons from International Experiences**. Toronto: Canadian Scholars' Press Inc., 123-153.

Raphael, D. (2015) "The political economy of health: a research agenda for addressing health inequalities in Canada." **Canadian Public Policy** 41 (Suppl 2), doi10.31.38/cpp.2014-084.

Raphael, D., and Curry-Stevens, A. (2004) "Conclusion: addressing and surmounting the political and social barriers to health." In D. Raphael (Ed.) **Social Determinants of Health: Canadian Perspectives** Toronto: Canadian Scholars' Press Inc., 345-360.

Raphael, D., Curry-Stevens, A., and Bryant, T. (2008) "Barriers to addressing the social determinants of health: insights from the Canadian experience." **Health Policy** 88 (2-3), 222-235.

Raphael, D., Brassolotto, J., and Baldeo, N. (2014) "Ideological and organizational components of differing public health strategies for addressing the social determinants of health." **Health Promotion International** 30 (4), 855-867.

Reddick, E. (2007) **Attitudes Towards Public Health Funding: Results of a Survey that Explored Differences in Support by Ontario Municipal Elected Officials for Local Public Health Programs**. MPA Research Report London, ON: Department of Political Science, The University of Western Ontario.
http://localgovernment.uwo.ca/resources/docs/research_papers/2007/Reddick,%20Elanie%20-%202007.pdf Retrieved on October 5, 2016.

Regional Municipality of Waterloo (2011) **Waterloo Region Profile Statistics, Trends and Forecasts: Background Document for the 2011-2014 Strategic Planning Process**. Waterloo, ON.
<http://www.regionofwaterloo.ca/en/regionalGovernment/resources/waterlooregionprofile.pdf> Retrieved on September 8, 2016.

Region of Waterloo Public Health (2010) **A Series of Public Health Briefs on Low Income Status: Low Income Status in Waterloo Region in 1996, 2001 and 2006**. Waterloo, ON: RoWPH.

<http://chd.region.waterloo.on.ca/en/researchResourcesPublications/resources/LowIncomeSeriesBrief.pdf> Retrieved on September 10, 2016.

Research in Motion (2007) **Annual Report 2006**. Waterloo: RIM

http://www.annualreports.com/HostedData/AnnualReportArchive/B/TSX_BB_2006.pdf

Retrieved on September 8, 2016.

Robertson, A. (1998) “Shifting discourses on health in Canada: from health promotion to population health.” **Health Promotion International** **13** (2), 155-166.

Sabatier, P.A. (1988) “An advocacy coalition framework of policy change and the role of policy oriented learning theorem.” **Policy Sciences** **21** (2-3), 129-168.

Sabatier, P., and Jenkins-Smith, H. (1993) **An Advocacy Coalition Approach**. Boulder, CO: Westview Press.

Salvaterra, R. (2015) Key informant interview, November 24, 2015.

Schumilas, T. (2006) “The evolution of the Health Determinants, Planning and Evaluation Division: The Region of Waterloo Public Health Department.” In R. Hofrichter (Ed.) **Tackling Health Inequities Through Public Health Practice: A Handbook for Action**. Washington DC: The National Association of City and County Health Officials, 177-184.

Schumilas, T. (2015) Key informant interview, November 27, 2015.

Seskar-Hencic, D. (2008) **Urbanization and Health Within Waterloo Region**. Waterloo, ON: Region of Waterloo Public Health.

Seskar-Hencic, D. (2015) Key informant interview, November 27, 2015.

Shankardass, K. et al. (2012) “Public awareness of income-related health inequalities in Ontario, Canada.” **International Journal for Equity in Health** **11**: 26.

Shewfelt, D. (2016) Key informant interview, February 12, 2016.

Simard, P., Sasseville, Mucha, J. et al. (2012) “Healthy cities, towns and communities in Canada: the current situation and challenges.” In I. Rootman, S. Dupere, A. Pederson, and M. O’Neill (Eds.) **Health Promotion in Canada: Critical Perspectives on Practice** (3rd Edition) Toronto: Canadian Scholars’ Press Inc., 172-175.

Social Planning Council of Sudbury (2009) **A Social Profile of Greater Sudbury**. Sudbury, ON: SPCS.
<http://spscudbury.ca/wp-content/uploads/2014/10/Social-Profile-of-Greater-Sudbury-2009-SPCS.pdf> Retrieved on September 14, 2016.

Stake, R.E. (2006) **Multiple Case Study Analysis** New York: The Guilford Press.

Stapleton, J. (2015) “Welfare backlash.” In **On Policy: The Long Shadow of Mike Harris** Toronto: Canadian Centre for Policy Alternatives, 12-16.
<https://www.policyalternatives.ca/publications/reports/onpolicy-long-shadow-mike-harris>
Retrieved on October 20, 2016.

Statistics Canada (1996) **Leeds, Grenville and Lanark District Health Unit Community Profile**. Ottawa: Statistics Canada.

Statistics Canada (1997) **Ontario Health Survey 1996-97**. Toronto: OMH.

Statistics Canada (2001a) **Peterborough City-County Health Unit 2001 Community Profile** Ottawa: Statistics Canada.
<https://www12.statcan.gc.ca/english/profil01/CP01/Details/Page.cfm?Lang=E&Geo1=HR&Code1=3555&Geo2=PR&Code2=35&Data=Count&SearchText=Peterborough%20County-City%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=&GeoCode=3555> Retrieved on August 23, 2016.

Statistics Canada (2001b) **Leeds, Grenville and Lanark District Health Unit 2001 Community Profile** Ottawa: Statistics Canada.
<https://www12.statcan.gc.ca/english/profil01/CP01/Details/Page.cfm?Lang=E&Geo1=HR&Code1=3543&Geo2=PR&Code2=35&Data=Count&SearchText=Leeds,%20Grenville%20and%20Lanark%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=&GeoCode=3543> Retrieved on August 25, 2016.

Statistics Canada (2001c) **Huron County Health Unit 2001 Community Profile**.
<https://www12.statcan.gc.ca/english/profil01/CP01/Details/Page.cfm?Lang=E&Geo1=HR&Code1=3539&Geo2=PR&Code2=35&Data=Count&SearchText=Huron%20County%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=&GeoCode=3539>
Retrieved on September 14, 2016.

Statistics Canada (2005) Canadian Community Health Survey Data, Household Food Insecurity, 2005 Peterborough vs Ontario. Cited in **Poverty in Peterborough City and County** Peterborough, ON: Root Causes of Poverty Working Group, Mayor's Action Committee, 24-25.

Statistics Canada (2006a) **Peterborough City-County Health Unit 2006 Community Profile**. Ottawa: Statistics Canada.
<http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/details/page.cfm?Lang=E&Geo1=HR&Code1=3555&Geo2=PR&Code2=35&Data=Count&SearchText=Peterborough%20County-City%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=3555> Retrieved on August 22, 2016.

Statistics Canada (2006b) **Waterloo Health Unit 2006 Community Profile**.
<http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/details/page.cfm?Lang=E&Geo1=HR&Code1=3565&Geo2=PR&Code2=35&Data=Count&SearchText=Waterloo%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=3565> Retrieved on September 5, 2016.

Statistics Canada (2006c) **Huron County Health Unit 2006 Community Profile**.
<http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/details/page.cfm?Lang=E&Geo1=HR&Code1=3539&Geo2=PR&Code2=35&Data=Count&SearchText=Huron%20County%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=3539> Retrieved on September 12, 2016.

Statistics Canada (2006d) **Sudbury and District Health Unit 2006 Community Profile**.
<http://www12.statcan.gc.ca/census-recensement/2006/dp-pd/prof/92-591/details/page.cfm?Lang=E&Geo1=HR&Code1=3561&Geo2=PR&Code2=35&Data=Count&SearchText=Sudbury%20and%20District%20Health%20Unit&SearchType=Begins&SearchPR=01&B1=All&GeoLevel=PR&GeoCode=3561>

Strand, M., and Fosse, E. (2011) "Tackling health inequalities in Norway: applying linear and non-linear models in the policy making process." **Critical Public Health** 21 (3), 373-381.

Stufflebeam, D.L., and Shinkfield, A.J. (2007) **Evaluation Theory, Models and Applications** San Francisco: Jossey-Bass.

Sudbury and District Health Unit (2009) **Taking Stock and Moving Forward: Sudbury and District Health Unit Actions to Reduce Social Inequities in Health**. Sudbury, ON: SDHU.

Sudbury and District Health Unit (2010) **Social Inequities in Health and the Sudbury and District Health Unit: Building Our Path for the Next 10 Years**. Sudbury, ON: SDHU.

Sudbury and District Health Unit (2011) **10 Promising Practices to Guide Public Health Practice to Reduce Social Inequities in Health** Sudbury, ON: SDHU.
<https://www.sdhu.com/health-topics-programs/health-equity/10-promising-practices-health-equity> Retrieved on September 15, 2016.

Sudbury and District Health Unit (2016) **Food insecurity**. Sudbury, ON: SDHU.
<https://www.sdhu.com/resources/research-statistics/health-statistics/sdhu-population-health-profile/health-behaviours/food-insecurity-health-profile>
Retrieved on September 15, 2016.

Sutcliffe, P. (2015) Key informant interview, December 15, 2015.

Sutcliffe, P., Snelling, S., and Lacle, S. (2009) **Research-oriented decision making to guide local public health practice to reduce social inequities in health** (Intervention Project Progress Report No. 2) Executive Training for Research Application (EXTRA). Sudbury, ON: Sudbury and District Health Unit.

Tarasuk, V.S., and Beaton, G.H. (1999) "Household food insecurity and hunger among families using food banks." **Canadian Journal of Public Health** 90 (2), 109-113.

Taylor, B. (2000) "Y(ikes) 2K quickly becomes Y(awn)2K." **Toronto Star** January 1, 2000, A3.
Thies, C.G. (2002) "A pragmatic guide to qualitative historical analysis in the study of international relations." **International Studies Perspectives** 3 (4), 351-372.

Tomalty, R. et al. (2007) **Ontario Community Sustainability Report 2007**. Toronto: The Pembina Institute.
<https://www.pembina.org/reports/ocsr-07-report.pdf> Retrieved on August 30, 2016.

True, J. et al. (2007) "Punctuated equilibrium theory." In P. Sabatier (Ed.) **Theories of the Policy Process** (2nd Ed). Boulder, CO: Westview Press.

Ursel, J. (1992) **Private Lives, Public Policy: 100 Years of State Intervention in the Family** Toronto: Women's Press.

Valverde, M. (1991) **The Age of Light, Soap and Water: Moral Reform in English Canada, 1885-1925** Toronto: McClelland and Stewart.

van Rijn, N., and Chung, A. (2000) "Hello world: We're Y2-OK!" **Toronto Star** January 1, 2000, A1, A17.

Wai, C. (2016) Personal communication, July 12, 2016.

Wallace, C.M., and Thomson, A. (1993) **Sudbury: Rail Town to Regional Capital**. Toronto: Dundurn Press.

Walt, G., Shiffman, J., Schneider, H. et al. (2008) “Doing health policy analysis: methodological and conceptual reflections and challenges.” **Health Policy and Planning** **23** (5), 308-317.

Warren, R. (1994) **Wealth and Health, Health and Wealth** Toronto: Premier’s Council on Health, Well-being and Social Justice.

Waterloo Region Public Health (2002) **Our Journey** Kitchener, ON: WRHU.

Waterloo Region Crime Prevention Council (2016) **A Timeline of the Waterloo Region Crime Prevention Council**. <http://preventingcrime.ca/wp-content/uploads/2015/05/HISTORIC-MILESTONES.pdf> Retrieved on September 11, 2016.

Waterloo Region Community Health Department (2001) **Our Journey - Growing Towards Healthy Public Policy: A 2 Year Progress Report** Waterloo, ON: Health Determinants Planning and Evaluation Division, Waterloo Region Community Health Department.

Weible, C.M., Sabatier, P.A., and McQueen, K. (2009) “Themes and variations: taking stock of the advocacy coalition framework.” **The Policy Studies Journal** **37** (1), 121-140.

Weible, C.M., and Schlager, E. (2016) “The multiple streams approach at the theoretical and empirical crossroads: an introduction to a special issue.” **The Policy Studies Journal** **44** (1), 5-12.

Weir, M. (1992) “Ideas and the politics of bounded innovation.” In “S. Steinmo et al (Eds) **Structuring Politics** Cambridge: Cambridge University Press, 186-216.

Whitehead M. (1992) “The concepts and principles of equity and health”. **International Journal of Health Services** **22**, 429–45.

World Health Organization (2008) **Closing the gap in a generation: Health equity through action on the social determinants of health** Geneva: WHO.

Yalzinian, A. (2007) **Ontario’s Growing Gap: Time for Leadership** Toronto: Canadian Centre for Policy Alternatives.
http://policyalternatives.ca/sites/default/files/uploads/publications/Ontario_Office_Pubs/2007/ontariogrowinggap.pdf Retrieved September 30, 2016.

Yin, R.K. (2009) **Case Study Research Design and Methods** (Fourth edition). Thousand Oaks California: Sage.

Yourk, D. (2002) "Inquest into welfare mother's death begins." **The Globe and Mail**, October 15, 2002.

Zahariadis, N., and Allen, C.S. (1995) "Ideas networks and policy streams: privatization in Britain and Germany" **Policy Studies Review** 14 (1-2), 71-98.

Zahariadis, N., and Exadaktylos, T. (2016) "Policies that succeed and programs that fail: ambiguity, conflict and crisis in Greek higher education." **Policy Studies Journal** 44 (1), 59-82.

Appendix A: Interview Questions for Medical Officers of Health

Part 1: Local Case Studies

1. Please tell me a bit about how you first became aware of the social determinants of health (SDH) and their importance in shaping the health status of individuals and communities.

Probes

- educational background
 - influential books/articles
 - key mentors
 - lived experience
2. When you first assumed your position as Medical Officer of Health (for the public health unit), did you feel that public health units could play a role in addressing the SDH? What were the key factors that influenced your opinion about health unit capacity, or lack of capacity, for action on the SDH?
 3. Thinking back to the time when your public health unit began to address the SDH in its scope of programs and services, how would you describe the level of community awareness about the SDH?
 4. Can you think of a key event, or events, in your community that increased awareness of the SDH? If so, please describe.

Probes:

- key signals of SDH deficit revealed by event
- coverage of event in local media
- expectations of health unit to play lead or supporting role in responding to event

5. What sources of information did you rely on to make the case for a greater focus on the SDH within your health unit?

Probes:

- local-level data
- provincial data
- SDH-focused reports produced by your health unit
- community stories/testimonials
- programs/activities taking place at other health units
- other (please describe)

6. What were the key facilitating factors that enabled you to incorporate a greater SDH focus into the scope of your programs/services?

Probes:

- support by key actors/local level champions
- support by community
- support by decision makers
- political ideology of decision makers
- feasibility
- cost
- realistically stated outcomes
- ability to monitor/measure outcomes
- capacity of staff to implement
- diversity of staff (i.e., did they reflect/relate to the community/communities you were trying to reach?)
- structural factors (e.g., organization of health unit)
- other factors?

7. What were the key limitations or barriers that impeded your ability to incorporate the SDH into your health unit programs/services?

Probes as above (but stated in negative).

8. How did you address these barriers?

9. In retrospect, what would you have done differently?

10. Is there anything else we haven't touched on that you'd like to add?

Part 2: Provincial Case Study (if applicable)

The final set of questions will focus on the 2005-2007 effort by a number of health units to integrate the SDH into the mandate of Ontario health units through the adoption of an SDH general and program standard. Before we discuss these questions, I'd like to briefly describe my understanding of this initiative. INTERVIEWER PROVIDES DESCRIPTION OF PROVINCIAL CASE.

11. Am I correct in my understanding? Have I missed anything?

12. Tell me what you recall about your involvement in this initiative.

13. How would you describe the level of awareness about the SDH during the time frame in question (2005-2007)?

Probes:

- public awareness
- professional awareness

14. Can you think of key provincial developments/events that inspired the effort to integrate the SDH into the mandate of Ontario's health units? If so, please describe.

Probes:

- key signals of SDH deficit revealed by event
- coverage of event in local media
- expectations of health units to play lead or supporting role in responding to event

15. What sources of information did you and others rely on to make the case for integrating the SDH into the mandate of Ontario health units?

Probes:

- local-level data
- provincial data
- community stories/testimonials
- SDH-focused reports produced by participating health units
- programs/activities taking place at health units
- seminal articles/documents
- other sources?

16. Please describe what you recall about the key activities to make the case for formally integrating the SDH into the mandate of Ontario health units.

Probes:

- development of draft general and program SDH standards (October-November 2005)
- planning forum at joint OPHA-aLPHa conference (November 2005)
- development and dissemination of draft framework document including proposed SDH standards (November 2005-March 2006)
- communications and meetings with MOHLTC Technical Review Committee and senior MOHLTC officials (2006-2007)

17. In your opinion, why did the effort to adopt SDH-specific general and program standards ultimately prove to be unsuccessful?

Probes:

- support by general public
- absence of key provincial actors/champions outside the public health sector
- support by decision makers in the MOHLTC
- support by provincial government
- support by key stakeholders (i.e., Association of Municipalities of Ontario)
- feasibility
- cost
- realistically stated outcomes
- perceived ideology underlying proposed standards
- ability to monitor/measure outcomes
- structural factors (e.g., organizational and system-level capacity for implementation)
- other factors?

18. In your opinion, did the 2005-2007 effort to integrate the SDH into the mandate of Ontario health units have a positive influence on subsequent developments such as the creation of the OPHS Foundational Standard and provincial funding for SDH nurses? Please elaborate.

Probes:

- compromise/tradeoffs in the 2005-2007 advocacy efforts that may have informed or given rise to subsequent developments

19. Looking back, do you feel that the timing was right for attempting to integrate SDH standards into the provincially directed mandate of Ontario health units? What conditions could have created a more favourable climate for achieving this objective?

20. In retrospect, what could have been done differently to 'make the case' for general and program standards that explicitly integrated the SDH into the mandate of Ontario health units?

21. Is there anything else we haven't touched on that you'd like to add?

Appendix B: Interview Questions for Public Health Unit Staff

Part 1: Local Case Studies

1. Please tell me a bit about how you first became aware of the social determinants of health (SDH) and their importance in shaping the health status of individuals and communities.

Probes

- educational background
 - influential books/articles
 - key mentors
 - lived experience
2. When you first assumed your position at (the public health unit), did you feel that public health units could play a role in addressing the SDH? What were the key factors that influenced your opinion about health unit capacity, or lack of capacity, for action on the SDH?
 3. Thinking back to the time when your public health unit began to address the SDH in its scope of programs and services, how would you describe the level of community awareness about the SDH?
 4. Can you think of a key event, or events, in your community that increased awareness of the SDH? If so, please describe.

Probes:

- key signals of SDH deficit revealed by event
- coverage of event in local media
- expectations of health unit to play lead or supporting role in responding to event

5. What sources of information did you rely on to make the case for a greater focus on the SDH within your health unit?

Probes:

- local-level data
- provincial data
- SDH-focused reports produced by your health unit
- community stories/testimonials
- programs/activities taking place at other health units
- other (please describe)

6. What were the key facilitating factors that enabled you to incorporate a greater SDH focus into the scope of your programs/services?

Probes:

- support by key actors/local level champions
- support by community
- support by decision makers
- political ideology of decision makers
- feasibility
- cost
- realistically stated outcomes
- ability to monitor/measure outcomes
- capacity of staff to implement
- diversity of staff (i.e., did they reflect/relate to the community/communities you were trying to reach?)
- structural factors (e.g., organization of health unit)
- other factors?

7. What were the key limitations or barriers that impeded your ability to address the SDH in your health unit programs/services?

Probes as above (but stated in negative).

8. How did you address these barriers?

9. In retrospect, what would you have done differently?

10. Is there anything else we haven't touched on that you'd like to add?

Part 2: Provincial Case Study (if applicable)

The final set of questions will focus on the 2005-2007 effort by a number of health units to integrate the SDH into the mandate of Ontario health units through the adoption of an SDH general and program standard. Before we discuss these questions, I'd like to briefly describe my understanding of this initiative. INTERVIEWER PROVIDES DESCRIPTION OF PROVINCIAL CASE.

11. Am I correct in my understanding? Have I missed anything?

12. Tell me what you recall about your involvement in this initiative.

13. How would you describe the level of awareness about the SDH during the time frame in question (2005-2007)?

Probes:

- public awareness
- professional awareness

14. Can you think of key provincial developments/events that inspired the effort to integrate the SDH into the mandate of Ontario's health units? If so, please describe.

Probes:

- key signals of SDH deficit revealed by event
- coverage of event in local media
- expectations of health units to play lead or supporting role in responding to event

15. What sources of information did you and others rely on to make the case for integrating the SDH into the mandate of Ontario health units?

Probes:

- local-level data
- provincial data
- community stories/testimonials
- SDH-focused reports produced by participating health units
- programs/activities taking place at health units
- seminal articles/documents
- other sources?

16. Please describe what you recall about the key activities to make the case for formally integrating the SDH into the mandate of Ontario health units.

Probes:

- development of draft general and program SDH standards (October-November 2005)
- planning forum at joint OPHA-aLPHa conference (November 2005)
- development and dissemination of draft framework document including proposed SDH standards (November 2005-March 2006)
- communications and meetings with MOHLTC Technical Review Committee and senior MOHLTC officials (2006-2007)

17. In your opinion, why did the effort to adopt SDH-specific general and program standards ultimately prove to be unsuccessful?

Probes:

- support by general public
- absence of key provincial actors/champions outside the public health sector
- support by decision makers in the MOHLTC
- support by provincial government
- support by key stakeholders (i.e., Association of Municipalities of Ontario)
- feasibility
- cost
- realistically stated outcomes
- perceived ideology underlying proposed standards
- ability to monitor/measure outcomes
- structural factors (e.g., organizational and system-level capacity for implementation)
- other factors?

18. In your opinion, did the 2005-2007 effort to integrate the SDH into the mandate of Ontario health units have a positive influence on subsequent developments such as the creation of the OPHS Foundational Standard and provincial funding for SDH nurses? Please elaborate.

Probes:

- compromise/tradeoffs in the 2005-2007 advocacy efforts that may have informed or given rise to subsequent developments

19. Looking back, do you feel that the timing was right for attempting to integrate SDH standards into the provincially directed mandate of Ontario health units? What conditions could have created a more favourable climate for achieving this objective?

20. In retrospect, what could have been done differently to 'make the case' for general and program standards that explicitly integrated the SDH into the mandate of Ontario health units?

21. Is there anything else we haven't touched on that you'd like to add?

Appendix C: Interview Questions for Community Partners/Allies

1. What do the social determinants of health mean to you?
2. Please tell me a bit about how you first became aware of the social determinants of health (SDH) and their importance in shaping the health individuals and communities.

Probes

- influential books/articles
 - lived experience
 - educational experience
 - dialogue with local health unit/medical officer of health
 - key events in the community
 - key individuals/influencers
 - other?
3. Thinking back to the time when your local health unit began to address the SDH in its scope of programs and services, how would you describe the level of community awareness about the SDH?
 4. Can you think of a key event, or events, in your community that increased awareness of the SDH-related issues addressed by your health unit? If so, please describe.

Probes:

- key signals of SDH deficit revealed by event
 - coverage of event in local media
 - expectations of health unit to play lead or supporting role in responding to event
5. Please describe your role in supporting the initiation of your health unit's efforts to address the SDH?

6. In your opinion, what were the key facilitating factors that enabled the health unit to proceed with these activities?

Probes:

- support by key actors/local level champions
- support by community
- support by decision makers
- political ideology of decision makers
- feasibility
- cost
- realistically stated outcomes
- ability to monitor/measure outcomes
- capacity of staff to implement
- diversity of staff (i.e., did they reflect/relate to the community/communities they were trying to reach?)
- structural factors (e.g., organization of health unit)
- other factors?

7. What were the key limitations or barriers that impeded your ability to address the SDH in your health unit programs/services?

Probes as above (but stated in negative).

8. How did you work with the health unit to address these barriers?

9. Looking back, do you feel that the timing was right for launching SDH-focused health unit activities in the community? What conditions could have created a more favourable climate for introducing these activities?

10. In retrospect, what would you have done differently to 'make the case' for a greater focus on the SDH by your local health unit?

11. Is there anything else we haven't touched on that you'd like to add?

Appendix D: Toronto Charter for a Healthy Canada (Endorsed by PCCHU Board of Health October, 2003)

From November 29 to December 1, 2002 a conference of over 400 Canadian social and health policy experts, community representatives, and health researchers met at York University in Toronto, Canada to: a) consider the state of ten key social or societal determinants of health across Canada; b) explore the implications of these conditions for the health of Canadians; and c) outline policy directions to improve the health of Canadians by influencing the quality of these determinants of health. The conference took place at a time when Canadian social and health policies were undergoing profound changes related to shifting political, economic, and social conditions. Ten social determinants of health – early life, education, employment and working conditions, food security, health services, housing, income and income distribution, social exclusion, social safety net, and unemployment and job insecurity were chosen on the basis of their prominence in Health Canada and World Health Organization policy statements and documents. The conference was a response to accumulating evidence that growing social and economic inequalities among Canadians are contributing to higher health care costs and other social burdens. Indeed, the Kirby Report on the Federal Role in Health Care points out that 75% of our health is determined by physical, social and economic environments. Evidence was also accumulating that a high level of poverty – an outcome of the growing gap between rich and poor – has profound societal effects as poor children are at higher risk for health and learning problems in childhood, adolescence, and later life, and are less likely to achieve their full potential as contributors to Canadian society. The Social Determinants of Health Across the Life-Span Conference coincided with the release of the Romanow Report on the Future of Health Care in Canada that called for strengthening the Canadian health care system by resisting privatization, expanding its coverage increasing its coverage, and increasing financial investment. The report also discusses the importance of economic and social determinants of health. The evidence heard at the Conference, also reinforced that immediate and long-term improvements in the health of Canadians depends upon investments that address the sources of health and disease.

The participants at the conference Social Determinants of Health Across the Life-Span Conference therefore resolve:

Whereas the evidence is overwhelming that the health of Canadians is profoundly affected by the social and economic determinants of health, including -- but not restricted to early life, education, employment and working conditions, food security, health care services, housing, income and its distribution, social exclusion, the social safety net, and unemployment and employment security.

Whereas the evidence presented at the conference clearly indicates that the state and quality of these key determinants of health are linked to Canada's political, economic and social environments and that many governments across Canada have not responded adequately to the growing threats to the health of Canadians in general, and the most vulnerable in particular; and

Whereas the evidence presented indicates that investments in the basic social determinants of health will profoundly improve the health of Canadians most exposed to health threatening conditions -- the poor, the marginalized, and those Canadians excluded from participation in aspects of Canadian society by virtue of their living conditions – therefore providing health benefits for all Canadians; and

Whereas the evidence presented to us has indicated the following to be the case:

1. Early childhood development is threatened by the lack of affordable licensed childcare and continuing high levels of family poverty. It has been demonstrated that licensed quality child improves developmental and health outcomes of Canadian children in general, and children-at risk in particular. Yet, while a national childcare program has been promised, 90% of Canadian families lack access to such care.

2. Education as delivered through the public education systems has helped to make Canada a world leader in educational outcomes. Our education systems are now at risk due to funding instability and poorly developed curriculum in many provinces. These conditions may weaken the trend toward greater number of students graduating despite evidence that those who do so show significantly better health and family functioning than non-graduates.

3. Employment and working conditions are deteriorating for some groups – especially young families -- with potential attendant health risks. One in three adult jobs are now either peripheral or precarious as a result of increasing contracting out of core jobs and privatization of public employment. These jobs are often temporary, with low pay and high stress. The weakening of labour legislation in many jurisdictions is directly related to precarious working situations. These changes threaten the gains made by workers in the past, jeopardizing their health and well-being.

4. Food security among Canadians and their families is declining – as a result of policies that reduce income and other resources available to low income Canadians. In Canada food insecurity exists among 10.2% of Canadian households representing 3 million people. Monthly food bank use is 747,665 or 2.4% of the total Canadian population – double the 1989 figure; 41% of the food bank users or 305,000 were children under the age of 18.

5. Health care services can become a social determinant of health by being reorganized to support health. Many examples of effective – but all-too-rarely implemented – means of preventing deterioration among the ill through chronic disease management and rehabilitation are available. Screening that has been carefully assessed for its effectiveness can support health. Preventing disease in the first place by promoting the social and living conditions that support healthy lifestyles has also been neglected. While the Romanow Report reaffirmed the principles of the Canada Health Act, missing were strong statements about the important roles public health, health promotion, and long-term care play in supporting health.

6. Housing shortages are creating a crisis of homelessness and housing insecurity in Canada. Lack of affordable housing is weakening other social determinants of health as many Canadians are spending more of their income on shelter. More than 18% of Canadians live in unacceptable housing situations and one in every five renter households spent 50% or more of their income on housing in 1996, an increase of 43% per cent since 1991.

7. Income and its equitable distribution have deteriorated the past decade. Despite a 7-year stretch of unprecedented economic growth, almost half of Canadian families have seen little benefit as their wages have stagnated. Governments at all levels have let the after-tax and transfer income gap between rich and poor grow from 4.8:1 in 1989 to 5.3:1 in 2000. The growing vulnerability of Canadians in lower income brackets threatens early childhood, education, food security, housing, and social exclusion, and ultimately, health. Low income Canadians are twice as likely to report poor health as compared to high income Canadians.

8. Social exclusion is becoming increasingly common among many Canadians. Social exclusion is the process by which Canadians are denied opportunities to participate in many aspects of cultural, economic, social, and political life. It is especially prevalent among those who are poor and New Canadians and members of racialized – or non-white – groups. As our racialized composition grows, it is unacceptable that these groups earn 30% less than whites and are twice as likely to be poor. These trends contribute to social and political instability in our society.

9. Social safety nets are changing in character as a result of shifting federal and provincial priorities. The 1990s has seen a weakening of these nets that constitute both threats to the health and well-being of the vulnerable. The social economy may provide opportunities for community organizations to provide services in more democratic, transparent and community-sensitive ways. It may be, however, unable to meet emerging needs without further burdening caregivers in the community or inadequately compensating them, many of whom are women.

10. Unemployment continues at high levels and employment security is weakening due to the growth of precarious, unstable and non-advancing jobs. Higher stress, increasing hours of work and increasing numbers of low income jobs are the mechanisms that link employment insecurity and unemployment to poor health incomes. Unionized jobs are the most likely to help avoid these health-threatening conditions.

11. And that Canadian women, Canadians of colour and New Canadians are especially vulnerable to the health threatening effects of these deteriorating conditions. This is most clear regarding income and its distribution, employment and working conditions, housing affordability, and the state of the social safety net.

It is therefore resolved that:

Governments at all levels review their current economic, social, and service policies to consider the impacts of their policies upon these social determinants of health. Areas of special importance are the provision of adequate income and social assistance levels, provision of affordable housing, development of quality childcare arrangements, and enforcement of anti-discrimination laws and human rights codes. It is also important to increase support for the social infrastructure including public education, social and health services, and improvement of job security and working conditions.

Public health and health care associations and agencies educate their members and staff concerning the impacts of governmental decisions upon the social determinants of health and advocate for the creation of positive health promoting conditions. Particularly important is their joining current debates about Canadian health and social policy directions and their potential impacts upon population health;

The media begin to seriously cover the rapidly expanding findings concerning the importance of the social determinants of health and their impacts upon the health of Canadians. This would strike a balance between the predominant coverage of health from a biomedical and lifestyle perspective. It would also help educate the Canadian public about the potential health impacts of various governmental decision-making and improve the potential for public involvement in public policymaking; and finally.

Immediate Action

As a means of moving this agenda forward, the conference recommends that Canada's Federal and Provincial/Territorial governments immediately address the sources of health and the root causes of illness by matching the \$1.5 billion targeted for diagnostic services in the Romanow Report on the Future of Health Care in Canada through an allocation of an equal amount towards two essential determinants of health for children and families: 1) affordable, safe housing; and 2) A universal system of high quality educational childcare.

Long-Term Action

Similar to governmental actions in response to the Acheson Inquiry into Health Inequalities in the United Kingdom, the federal government should establish a Social Determinants of Health Task Force to consider the findings and work to implement the implications of the material presented at this Conference. The Task Force would operate as does the National Council on Welfare to identify and advocate for policies to support population health by all levels of governmental operation. The federal and provincial governments would respond to these recommendations in a formal manner through annual reports on the status of these social determinants of health.

So resolved, this December 1, 2002, in Toronto, Canada.

Appendix E: Determinants of Health Prioritization Tool (Huron County Health Unit)

Prioritization tool / questions

1. Is there a community need? And how do you know?
2. Is there an established strategy known to impact the issue?
3. Do we have the resources to implement the strategy?
4. Is there someone else doing it?
5. Is the strategy acceptable to the community?
6. Is it focused on the right group?
7. What is the impact if not done?

Determinants of Health?

1. Is the “need” a determinant of health?
2. If the program is prescriptive, how can we deliver the program to those most at risk or to whom the program is usually the least accessible?
3. Does one of your outcomes impact any determinants of health?

Appendix F: Sudbury and District Board of Health Determinants of Health Position Statement (2005)

Position

The Sudbury & District Board of Health uses a population health approach to improve the health of the entire population in its catchment area and to reduce health inequities among population groups. Health improvements are achieved through effective action on the broad range of factors and conditions that determine health. Health inequities are reduced by focusing on vulnerable populations. The broad determinants of health are addressed in each life stage: childhood and youth, mid-life and later life. The Sudbury & District Board of Health recognizes that efforts to improve population health require evidence-based strategies, strong partnerships within and outside of the traditional health sector, and flexibility in the face of complex challenges.

Background

Why are some Canadians healthy and others not? There is a growing body of evidence about what makes and keeps people healthy. In 1974 the landmark Health and Welfare Canada, *Lalonde Report*, described a framework of key factors that determine health status: lifestyle, environment, human biology and health services. Since that time, this simple framework has been refined and expanded. The *population health approach* builds on the Lalonde framework and recognizes that health depends on more than access to a good health care system. Excellent scientific research has established that factors such as living and working conditions and how we share wealth in our societies are crucially important for a healthy population.

Commonly referred to as the *determinants of health*, these broad factors impact on individual and population health. The determinants of health are each important in their own right, however, they interact to forcefully influence health and well being across the lifespan.

Although the determinants of health can be described in many ways, the Sudbury & District Board of Health uses the Public Health Agency of Canada categorization of the twelve major determinants.

The 12 Determinants of Health

1. **Income and social status:** There is strong and growing evidence that higher social and economic status is associated with better health. In fact, these two factors seem to be the most important determinants of health.
2. **Social support networks:** The health effects of social relationships may be as important as established risk factors such as smoking, physical activity, obesity, and high blood pressure.
3. **Education and literacy:** People with higher levels of education have better access to healthy physical environments for their families. Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health and to die earlier than Canadians with high levels of literacy.
4. **Employment/Working conditions:** employment provides not only money but also a sense of identity and purpose, social contacts and opportunities for personal growth. Unemployed people have a reduced life expectancy and suffer significantly more health problems.

Conditions at work, both physical and psychosocial, can have a profound effect on people's health and emotional wellbeing.
5. **Social environments:** Effective social and community responses can add resources to an individual's choices of strategies to cope with changes and foster health.
6. **Physical environments:** At certain levels of exposure, contaminants in our air, water, food and soil can cause a variety of adverse health effects. In the built environment, factors related to housing, indoor air quality, and the design of communities and transportation systems can significantly influence our physical and psychological well-being.
7. **Personal health practices and coping skills:** There is growing recognition that personal health choices are greatly influenced by the socioeconomic environments in which people live, learn, work and play.
8. **Healthy child development:** The effect of prenatal and early childhood experiences on health in later life, well-being, coping skills and competence is very powerful. Positive stimulation early in life improves learning, behaviour and health into adulthood.
9. **Biology and genetic endowment:** The basic biology and organic make-up of the human body are a fundamental determinant of health. Genetic endowment provides an inherited predisposition to a wide range of responses that affect health status and appears to predispose certain individuals to particular diseases or health problems.
10. **Health services:** Health services designed to maintain and promote health, to prevent disease, and to restore health and function contribute to population health.

11. Gender: Gender refers to the array of society-determined roles, personality traits, attitudes, behaviours, values, relative power and influence that society ascribes to the two sexes on a differential basis. “Gendered” norms influence the health system’s practices and priorities.
12. Culture: Some persons or groups may face additional health risks largely due to a socio-economic environment which is determined by dominant cultural values that may perpetuate conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally sensitive appropriate health care and services.

Reference

Public Health Agency of Canada <http://www.phac-aspc.gc.ca/ph-sp/phdd/>

**Appendix G: Determinants of Health - Developing an Action Plan for
Public Health - Joint aLPHa-OPHA Conference Session, November 22-23, 2005**

AGENDA

Tuesday November 22, 2005

9:00-9:45 am **Keynote address: Tackling Inequalities in Health: the UK Experience**
Dr. David Gordon, Director, Townsend Centre for International Poverty
Research, University of Bristol

10:15-10:45 am **Concurrent Session I**

Moderator: Dr. Penny Sutcliffe
Medical Officer of Health & CEO, Sudbury & District Health Unit

Lead Facilitator: Brian Hyndman
Consultant, The Health Communications Unit & The Alder Group

**Featured Presentation: Healthy People, Healthy Communities: Using
the Population Health Approach in Nova Scotia**
Heather Christian, Coordinator, Population Health, Public Health, Nova
Scotia Department of Health/Health Promotion

Panel Discussion

Public health leaders from across the province will inspire participants
with their own experiences incorporating a determinants of health
perspective into local programs, policies and practice.

2:00-3:30 pm **Concurrent Session II**

**Presentation: An overview of the timely advocacy work that has been
initiated by a collaboration of local Medical Officers of Health.**
Dr. Rosanna Pellizzari, Medical Officer of Health, Perth District
Health Unit

***Collaborative Development of a Determinants of Health Action Plan for
Public Health***

4:00-5:00 pm **Concurrent Session III**

***Collaborative Development of a Determinants of Health Action Plan for
Public Health***

Wednesday November 23, 2005

10:00-11:30 am Concurrent Session IV

Collaborative Development of a Determinants of Health Action Plan for Public Health

2:00-3:30 pm Concurrent Session V

Discussion

Input gathered during the previous four concurrent sessions will be presented as a draft Determinants of Health Action Plan for Public Health.

3:45-4:45 pm

Closing Panel

Dr. Sheela Basrur, Ontario's Chief Medical Officer of Health
Dr. David Butler-Jones, Canada's Chief Public Health Officer
Dr. Geoff Dunkley, Ontario Health Protection and Promotion Agency Implementation Task Force

The panel will hear and respond to key public health recommendations arising from the conference in the areas of Determinants of Health, Chronic Disease Prevention, Injury Prevention, and Infection Control.

***Determinants of Health: Developing an Action Plan for Public Health* is being presented by the Sudbury & District Health Unit, in consultation with the following public health representatives from across the province:**

**Grey-Bruce Health Unit
Haliburton, Kawartha Pine Ridge Health Unit
The Health Communications Unit
Huron County Health Unit
Leeds, Grenville and Lanark District Health Unit**

**Northwestern Health Unit
Ontario Prevention Clearinghouse
Perth District Health Unit
Peterborough City-County Health Unit
Region of Waterloo Public Health
Toronto Public Health**

Appendix H: Draft Proposed General and Program Standards for the Social Determinants of Health (2005)

Overview of Determinants of Health Stream at the Joint Conference of the Association of Local Public Health Agencies (alPHA) and the Ontario Public Health Association (OPHA) Determining Health Through Public Health Action.

GENERAL STANDARD / FRAMEWORK ON SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

GOAL:

To improve the health of all of the population by reducing the social, economic and cultural inequalities and conditions which cause ill health.

Objectives:

1. To ensure that all programs and services explicitly address the social and economic determinants of health as appropriate.

PROPOSED PROGRAM STANDARD SOCIAL AND ECONOMIC DETERMINANTS OF HEALTH

INCOME EQUALITY

Objective would relate:

1. To increase the number of people who have the financial resources to meet basic needs (i.e. a living wage, adequate social assistance, etc.)

SAFE AND AFFORDABLE HOUSING

Objective:

1. To increase the number of people who are living in safe and affordable housing (i.e. social housing, various forms of rent support, etc.)

EDUCATION / SKILL BUILDING / LITERACY

Objectives:

1. To increase opportunities for education and skill building for all people.
2. To increase the percentage of people who achieve a minimum grade 12 literacy and numeracy level.

SOCIAL INCLUSION

Objective:

1. To increase the proportion of the population who report a sense of community, social connection and inclusion.

FOOD SECURITY

Objective:

1. To increase the proportion of the population who have access to affordable, healthy, locally produced food.

EMPLOYMENT AND JOB SECURITY / ECONOMY

Objective:

1. To increase the proportion of the population who have access to secure and satisfying employment.

COMMUNITY CAPACITY / PARTNERSHIPS

Objectives:

1. To increase public knowledge and understanding of the social and economic determinants that affect individual and community health and well-being.
2. To increase and strengthen partnerships with organizations/agencies and communities engaged to act on the social and economic determinants of health.
3. To increase citizen engagement and influence in decision-making aimed at reducing health inequalities.

ACCESS TO SERVICES

Objectives:

1. To reduce educational, social and environmental barriers to accessing public health services that promote equity in health.
2. To increase access to services that promotes equity in health (e.g. day care, dental, etc.).

MENTAL HEALTH PROMOTION

Objective:

1. To improve the mental health status of the general population (children, youth, adults, and older adults.)

RESEARCH

Objective:

1. To increase the number of research and evaluation initiatives which increase public health unit understanding of the social and economic determinants of health in their community and the number of intervention evaluations related to the social and economic determinants of health.

Appendix I: Ontario Public Health Association (OPHA) Resolution on the Determinants of Health (Code 2005-03 RES)

Submitted by the Sudbury & District Health Unit in collaboration with the Reference Panel, November 23, 2005.

Resolution

WHEREAS international and national bodies increasingly recognize the importance of policy and programme development that explicitly address the root causes of ill health, health inequalities and the needs of those who are affected by poverty and social disadvantage; and

WHEREAS the Ontario Public Health Association (OPHA) and many Ontario public health agencies/units have acknowledged the importance of social and broader determinants of health to their public health work and have supported and implemented related public health policies and programmes; and

WHEREAS the Determining Health through Public Health Action 2005 joint OPHA/alPHa (Association of Local Public Health Agencies) conference including the Determinants of Health: Developing an Action Plan for Public Health stream has explicitly created opportunities for awareness promotion, informed public health debate and action recommendations on social and broader determinants of health with the goals of informing local public health practice and provincial public health policy/mandate on social and broader determinants of health;

THEREFORE BE IT RESOLVED THAT the OPHA request the Chief Medical Officer of Health for Ontario to engage in an inclusive process to examine the role of Ontario's public health system in addressing social and broader determinants of health; and

FURTHER THAT this examination inform the current local public health capacity review process, the review and revision of the Mandatory Health Programs and Services Guidelines, and the scope and role of the proposed Health Protection and Promotion Agency; and

FURTHER THAT a copy of this motion be forwarded to the Chief Medical Officer of Health for Ontario, the Ministers of Health and Long-Term Care, Children and Youth Services and Health Promotion, the Boards and constituent societies of OPHA and alPHa, and the Public Health Agency of Canada for their information and review.

Appendix J: Determinants of Health as a Mandatory Public Health Program Association of Local Public Health Agencies Resolution (2005 A05-14)

WHEREAS Canada's Minister of State for Public Health has declared that "poor living conditions such as poverty, food insecurity, family violence, inadequate housing, unsafe environmental conditions, social discrimination, poor working conditions and lack of education...are often the root causes of poor health" and that "finding strategies to improve these social determinants is equally, and in some cases, more important to health status than medical care and improving personal health behaviours." ; and

WHEREAS 1,065,000 children (nearly one in six), lives in poverty, 18% live in deep poverty, and 14,000 people are homeless in Canada; and

WHEREAS there are strong associations of health inequities with identifiable subpopulations (e.g. Aboriginal people, immigrants, the physically / mentally disabled) putting them at greater risk of illness and preventable death; and

WHEREAS the Health Council of Canada (HCC) has concluded that increases in health care spending without targeting the socio-economic needs of people at greatest risk will not reduce health disparities and advised that the First Ministers' work on reducing health disparities should be given high priority; and

WHEREAS the HCC has made the following three recommendations: Health promotion strategies should be broadened beyond lifestyle issues to focus on health disparities through a broad intersectoral approach; Since health disparities are the "number one health problem in the country", the gap between groups in Canada must be reported and highlighted; Targets for the reduction of health disparities must be set; and

WHEREAS the HCC has called for "strong language" in order to increase public awareness of the critical role of socio-economic disparities in health outcomes and health care system utilization; and

WHEREAS in Ontario, public health units are well situated within communities and the health sector to speak to and act on these determinants of health; and

WHEREAS the appointment of a new Minister for Health Promotion in Ontario and a planned major review of public health's Mandatory Health Programs and Services Guidelines by Ontario's Chief Medical Officer of Health create opportunities to address the determinants of health as a population-based health promotion intervention;

NOW THEREFORE BE IT RESOLVED THAT the Association of Local Public Health Agencies (alPHa) request that the Mandatory Health Programs and Services Guidelines be revised to include the Determinants of Health as a recognized health program and service area and planning framework for all Ontario boards of health;

AND FURTHER THAT alPHa request Ontario's Chief Medical Officer of Health to appoint an expert committee with intersectoral membership and strong public health representation to develop evidence-based goals, objectives, requirements, standards and evaluation framework, as well as a timely implementation strategy for this new Mandatory Program;

AND FURTHER THAT alPHa requests that the determinants of health be incorporated into the scope and function of the new Health Protection and Promotion Agency;

AND FURTHER THAT the alPHa Board encourage all Ontario boards of health to incorporate a broad determinants of health approach into organizational mission statements and strategic plans;

AND FURTHER THAT alPHa facilitates the identification of opportunities for advocacy on broad determinants of health and work with its members to enhance their role as effective change agents to address health disparities and improve health outcomes, recognizing the roles and responsibilities of other agencies, ministries and governments."

Appendix K
Determinants of Health Report - Information Meeting

01/15/2007
2:30-4:30

DMO Boardroom, 777 Bay Street, 18th Floor

Attendees:

Public Health Units	Dr. Penny Sutcliffe, Sudbury & District Health Unit Medical Officer of Health Dr. Charles Gardner, Simcoe-Muskoka District Health Unit Medical Officer of Health Dr. Pete Sarsfeld, Northwestern Health Unit Medical Officer of Health Sandra Laclé, Director, Health Promotion Division, Sudbury and District Health Unit Isabel Michel, Director, Resources, Research, Evaluation and Development Division, Sudbury and District Health Unit
Ministry of Health and Long-Term	Dr. George Pasut, Acting Medical Officer of Health, Public Health Division Phil Jackson, Director, Strategic Planning & Implementation Branch Monika Turner, Director, Public Health Standards Branch Paulina Salamo, Manager, Program Standards Branch Karen Singh, Acting Manager, Strategic Planning & Implementation Branch
Ministry of Health Promotion	Jean Lam, Assistant Deputy Minister Lisa Watson, Director, Strategic Policy and Planning Branch Pegeen Walsh, Director, Chronic Disease Prevention and Health Promotion Branch Dr. Jack Lee, Strategic Advisor to CMOH, MHP Enza Ronaldi, Manager, Strategic Policy and Planning Branch Jas Chana, Senior Policy Advisor, Chronic Disease Prevention and Health Promotion Branch Holly Big Canoe, Director, Strategic Planning Branch
Ministry of Children and Youth Services	

Agenda

1. Introduction - George Pasut
2. Overview of Sudbury paper to be presented by Dr. Penny Sutcliffe and other Public Health Unit Representatives
3. Open Discussion
4. Wrap-up

Social Determinant of Health Sample goals and activities based on aPHa/OPHA Conference recommendations	Community Level Indicators	Data Sources
<p>Education</p> <p>Goal To ensure that all citizens have access to quality and diverse education and training opportunities.</p> <p>Activities</p> <p>Advocacy The Board of Health shall advocate for and support quality and diverse education and training opportunities for both children and adults.</p> <p>Programming The Board of Health shall develop and enhance quality and diverse education and training opportunities.</p> <p>Community Capacity/Partnerships The Board of Health shall work collaboratively with community partners to advocate for, develop and/or enhance quality and diverse education and training opportunities.</p> <p>Research/Reporting The Board of Health shall produce an annual report documenting community indicators and trends related to education levels.</p>	<p>APHEO Core Indicators</p> <p><i>Education level</i> - Proportion of population 15 years and over by level of schooling attained relative to the total non-institutional population 15 years and over.</p> <p>Other possible indicators</p> <ul style="list-style-type: none"> • Adult functional literacy rate • Proportion of children meeting developmental standards 	<ul style="list-style-type: none"> • Canadian Census

Social Determinant of Health Sample goals and activities based on aPHa/OPHA Conference recommendations	Community Level Indicators	Data Sources
<p>Employment</p> <p>Goal To ensure that all citizens have access to quality and satisfying employment opportunities that enables them to meet their basic needs.</p> <p>Activities</p> <p>Advocacy The Board of Health shall advocate for and support policies that increase employment opportunities, strengthen economic development and provide a living wage for all citizens.</p> <p>Programming The Board of Health shall develop and enhance initiatives that increase opportunities for quality and satisfying employment.</p> <p>Community Capacity/Partnerships The Board of Health shall work collaboratively with community partners to advocate for, develop and/or enhance policies and initiatives that increase opportunities for quality and satisfying employment.</p> <p>Research/Reporting The Board of Health shall produce an annual report documenting community indicators and trends related to employment patterns and wage levels.</p>	<p>APHEO Core Indicators</p> <p><i>Labour force participation rate</i> - Proportion of the population 15 years of age and over, excluding institutional residents, who reported that they were not in the labour force in the week (Sunday to Saturday) prior to Census Day.</p> <p><i>Youth unemployment rate</i> - Proportion of the population 15-24 years unemployed relative to the total non-institutional population 15-24 years in the labour force in the week prior to Census Day.</p> <p><i>Long-term unemployment rate</i> - Labour force aged 15 and over who did not have a job any time during the current or previous year.</p> <p><i>Proportion with work stress</i> - Proportion of the working population aged 20-64 who self-reported that most days at work were “quite a bit stressful” or “extremely stressful” in the past 12 months.</p> <p>Other possible indicators</p> <p><i>Minimum wage</i> as a percentage of basic needs poverty line or LICO (based on full year of work, 40 hours/week)</p> <p><i>Proportion of individuals working for < \$10hr</i></p> <p><i>Proportion of individuals in each of permanent, contract and casual jobs</i></p>	<ul style="list-style-type: none"> • Canadian Census • Canadian Community Health Survey (CCHS) • Labour Force Survey

Social Determinant of Health Sample goals and activities based on aPHa/OPHA Conference recommendations	Community Level Indicators	Data Sources
<p>Housing</p> <p>Goal To ensure that all citizens have access to adequate, affordable and safe housing.</p> <p>Activities</p> <p>Advocacy The Board of Health shall advocate for and support policies that increase access to adequate, affordable and safe housing.</p> <p>Programming The Board of Health shall develop and enhance initiatives that increase access to adequate, affordable and safe housing.</p> <p>Community Capacity/Partnerships The Board of Health shall work collaboratively with community partners to advocate for, develop and/or enhance policies and initiatives that increase access to adequate, affordable and safe housing.</p> <p>Research/Reporting The Board of Health shall produce an annual report documenting community indicators and trends related to the accessibility/availability of adequate, affordable and safe housing.</p>	<p>APHEO Core Indicators</p> <p><i>Housing affordability for renters/owners/total</i> - Households (renters, owners, and total) spending 30% or more of total household income on shelter expenses. Shelter expenses include payments for electricity, oil, gas, coal, wood or other fuels, water and other municipal services, monthly mortgage payments, property taxes, condominium fees and rent.</p> <p>Other possible indicators</p> <p><i>Number of individuals who are homeless or at risk of homelessness</i></p> <p><i>Utilization of local shelters</i></p> <p><i>Number of individuals/families on local waitlists for social housing</i></p> <p><i>Vacancy rate</i></p>	<ul style="list-style-type: none"> • Canadian Census • Local data source • Local data source • Municipal Housing Authority • Canada Mortgage and Housing Corporation

Social Determinant of Health Sample goals and activities based on aPHa/OPHA Conference recommendations	Community Level Indicators	Data Sources
<p>Social Inclusion</p> <p>Goal To ensure that all citizens report a sense of social inclusion and have opportunities for meaningful participation in community life.</p> <p>Activities</p> <p>Advocacy The Board of Health shall advocate for and support policies and initiatives that encourage social inclusion, community participation and civic engagement.</p> <p>Programming The Board of Health shall develop and enhance initiatives that increase social inclusion and opportunities for meaningful participation in community life.</p> <p>Community Capacity/Partnerships The Board of Health shall work collaboratively with community partners to advocate for, develop and/or enhance policies and initiatives that increase social inclusion and opportunities for meaningful participation in community life.</p> <p>Research/Reporting The Board of Health shall produce an annual report documenting community indicators and trends related to social inclusion.</p>	<p>Other Indicators</p> <p><i>Proportion of individuals that rate their sense of community belonging as very strong</i></p> <p><i>Proportion of individuals reporting a high degree of social support</i></p> <p><i>Availability of Social Support</i></p> <p><i>Utilization of Social Support</i></p> <p><i>Note: Other social and economic determinants indicators that contribute to exclusion – poverty, housing, education, etc, are frequently used to measure social inclusion.</i></p>	<ul style="list-style-type: none"> • Canadian Community Health Survey (CCHS) • CCHS • CCHS • CCHS

Social Determinant of Health Sample goals and activities based on aPHa/OPHA Conference recommendations	Community Level Indicators	Data Sources
<p>Food Security</p> <p>Goal To ensure that all citizens have access to nutritious, affordable, appropriate and locally produced food.</p> <p>Activities</p> <p>Advocacy The Board of Health shall advocate for and support policies and initiatives that increase access to nutritious, affordable, appropriate and locally produced food.</p> <p>Programming The Board of Health shall develop and enhance initiatives that increase access to nutritious, affordable, appropriate and locally produced food.</p> <p>Community Capacity/Partnerships The Board of Health shall work collaboratively with community partners to advocate for, develop and/or enhance policies and initiatives that increase access to nutritious, affordable, appropriate and locally produced food.</p> <p>Research/Reporting The Board of Health shall produce an annual report documenting community indicators and trends related to food security.</p>	<p>APHEO Core Indicators</p> <p><i>Food insecurity rate</i> - Proportion of the population who, because of lack of money, worried that there would not be enough to eat or didn't have enough food to eat or didn't eat the quality or variety of foods that they wanted to eat.</p> <p>Other possible indicators</p> <p><i>Utilization of local food banks</i></p> <p><i>Cost of nutritious food basket (as a percentage of average incomes and social assistance rates)</i></p>	<ul style="list-style-type: none"> • Canadian Community Health Survey • Local data source/Canadian Association of Foodbanks • Local health unit data