Understandings of health equity and organizational constraints on health equity work among frontline public health practitioners in British Columbia

by

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We acknowledge and respect the Lək̓ʷəŋən (Songhees and Esquimalt) Peoples on whose territory the university stands, and the Lək̓ʷəŋən and W̱SÁNEĆ Peoples whose historical relationships with the land continue to this day.

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Abstract

Health equity occupies a central place in the field of public health. However, significant challenges exist to public health practitioners promoting health equity, many of which are produced by the organizational contexts in which they work. This study explored how frontline public health staff engaged with health equity during a time when the organization they worked for had declared health equity an organizational priority. The project involved secondary analysis of focus groups and interviews conducted in 2014-2015 with frontline practitioners in a health authority in British Columbia, Canada. Using a critical discursive organizational approach, I identified a number of ideas at work in frontline staff's construction of health equity. Frontline staff prioritized health equity in their work, even if they did not always use the term 'health equity'. They most often articulated health equity as downstream access to services and less often as an upstream structural phenomenon. Some articulated concerning individualist ideas about health equity that pushed back against systemic approaches. Frontline staff described an organizational environment that mostly impeded their ability to promote health equity through inadequate resources, bureaucratization, an overemphasis on targeted programs, and limited professional scope. They posited that the organization's lack of prioritization of health equity and the hierarchical distance between senior leaders and the frontline produced an organizational environment that was unsympathetic to and unsupportive of health equity. This research highlighted some of the relations of power that impacted frontline public health staff's ideas and action on health equity, concluding that the conditions and dynamics of the organizational environment are critical factors in organization-wide health equity initiatives. It also raised concerns about how the concept of health equity plays out in real world public health contexts, questioning whether the concept is politically generative at the level of frontline practice.

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Acknowledgements

This thesis was written in Mi’kma’ki, the ancestral and unceded territory of the Mi’kmaq People. This territory is covered by the treaties of Peace and Friendship, which were first signed by the Mi’kmaq, Wolastoqey, Peskotomuhkatiyik, and the British Crown in 1726.

Chapter One: Introduction

Health inequities have been identified as a significant threat to population health, within Canada and internationally (Marmot et al., 2008; Pan-American Health Organization, 2019; Raphael et al., 2020). Health inequities are differences in health status or outcomes that are unfair, unjust, socially produced, and therefore alterable (Braveman, 2014; Braveman et al., 2011). The widely accepted idea of health equity in the field of public health implies that "ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance" (Whitehead & Dahlgren, 2006). Unfortunately, inequities in socially determined circumstances abound; power and resources are inequitably distributed among people, producing inequities in health (Marmot et al., 2008; Pan-American Health Organization, 2019; Solar & Irwin, 2010).

Health equity and related concepts have occupied a central position in public health for decades (Fee & Gonzalez, 2017; Yao et al., 2019) and health equity has become one of the key ethical and conceptual pillars of the field (e.g., World Health Organization, 1986). Within contemporary health systems, public health is uniquely concerned with addressing both inequities in health and inequities in the social circumstances (or determinants) that produce those inequities. Public health has a number of key roles to play in promoting health equity, including assessing and reporting on inequities, modifying interventions to reduce inequities, partnering with other sectors and participating in policy development (National Collaborating Centre for Determinants of Health, 2013a). Despite these laudable articulations, public health has faced challenges in translating commitments to health equity into sufficient concrete action – these challenges form a key area of scholarship and practice.

In Canada, there are calls for public health systems to implement organization-wide interventions focused on health equity or in which health equity figures prominently, but progress in this area has been slow (Brushett et al., 2022; Gardner, 2012; Kouri, 2013; Mador, 2010; National Collaborating Centre for Determinants of Health, 2014). In the 2000s, the province of British Columbia, Canada took up this call by working to build structures and processes for health equity into its systems and services as part of the renewal and restructuring of public health. Initially, this work involved the 2005 Core Functions Framework initiative, a project undertaken to map out the core functions of a high-quality public health system and ensure that some part of the organization was responsible for each function. The Framework included 21 program areas, four public health strategies (e.g., health promotion, disease surveillance) and two lenses, or analytical approaches to programming – the Population Lens and the Health Inequalities Lens.

The commitment to anchoring the concept of health equity in BC's public health system was reaffirmed in the 2013 release and 2017 update of *BC's Guiding Framework for Public Health* (Province of British Columbia & Ministry of Health, 2013). The Guiding Framework articulated seven goals for public health in BC (which are essentially a condensed version of the 21 program areas from the 2005 Core Functions Framework) as well as public health's role in population health and in health equity. Despite these key provincial public health policy documents explicitly naming the importance of public health programming considering health equity in all its activities, organizational actors in BC have faced challenges in translating these policy directions into action (Pauly et al., 2021; van Roode et al., 2020).

The challenges faced in BC are not unique to that jurisdiction – public health practitioners working to promote health equity internationally often find that they encounter significant barriers to action, many of which concern the organizational context in which they work (McMahon, 2022; Orton et al., 2011; Pauly et al., 2021; van Roode et al., 2020). Frontline staff, and nurses in particular, make up a significant proportion of Canada's public health workforce (National Collaborating Centre for Determinants of Health, 2015; Public Health Agency of Canada, 2008) and are responsible for the bulk of the day-to-day work in the field. Public health nurses tend to have ethical and practice orientations that are unique compared to their acute care colleagues, such as commitments to accessibility, cultural proficiency, harm reduction and the social determinants of health (Cusack et al., 2017). Paying attention to frontline staff's experiences, including the organizational factors that influence those experiences, provides an important window into health equity work in public health. Examining practitioners' experiences of health equity related work can illuminate how the conditions in which they work impact their ability to take action to promote health equity, and how such action can be supported, both by large-scale organizational initiatives such as the Core Functions Framework and Guiding Framework for Public Health and in everyday public health practice. My hope in this project is to support those committed to health equity to better understand how public health organizations might contribute to reducing health inequities, in the pursuit of social justice.

The rise of health equity as a concept in the field of public health in the last decade or so invites us to take a critical look at the meaning of this concept and how it is being applied. Health equity means different things to different people and health equity action varies widely depending on conceptual underpinnings, the actor(s) involved, and the political and organizational context, among other factors (Knight, 2014; McMahon, 2022; Pauly et al., 2017; Rizzi, 2014). Health equity scholarship highlights that not all understandings of and action on health equity are equal – that is, not all conceptual frameworks and interventions lead to the same kinds or same magnitudes of decreases in health inequities (Lorenc et al., 2013; Macintyre, 2007; McCartney et al., 2013).

In the 15 years since the World Health Organization's Commission on the Social Determinants of Health highlighted the role that "the inequitable distribution of power, money, and resources" (Marmot et al., 2008, p. 2) plays in shaping health and health equity, scholars and practitioners working on population health have paid increased attention to the structural determinants of health, recognizing that a focus on the social determinants of health is insufficient to inform substantive equity action (Heller et al., 2024). Empirical evidence has also accumulated that asserts that structural interventions have a greater impact on reducing inequities than interventions aimed at altering social conditions or individual level behaviour (McCartney et al., 2013).

Given that the application of certain conceptual formulations of health equity make a comparatively small or even negative impact on health inequities, it is important for public health systems and practitioners to evaluate the degree to which various conceptual understandings should be prioritized in organizational and individual action. Understandings of health equity that draw attention to the structural factors that produce health and other inequities (Marmot et al., 2008; Pan-American Health Organization, 2019) must be central to public health practice and scholarship. This inquiry can also contribute to a deeper understanding of the contemporary utility and limitations of the concept of health equity.

This diversity of conceptual formulations of health equity becomes even more complex when concepts play out in organizational contexts. Despite Canadian public health organizations increasingly making policy commitments to health equity, some of the barriers to health equity action come from within these organizations (McMahon, 2022; National Collaborating Centre for Determinants of Health, 2011; van Roode et al., 2020). Various actors involved in contemporary Canadian public health – frontline staff, managers, administrators, senior leaders, and government officials – may have different conceptual understandings of health equity and different ideas about which understandings should guide action. However, given the corporate organizational hierarchy governing Canadian health systems, these actors have different levels of organizational power to shape ideas and action. Which formulations of health equity are formally or informally endorsed by an organization, or how the structures, policies and practices of the organization enable and constrain the practices of each actor, depends in part on ideas about health equity in circulation and on the distribution of power in the organization. Investigating the experiences of frontline staff using a lens of organizational power may help us understand what prevents declarations of commitment to health equity from translating into action.

My thesis project asks: *How do frontline public health staff engage with health equity during a time when the organization they work for has declared health equity an organizational priority?* In order to answer this question, I focused on two key elements: conceptual understandings of health equity and the relational and organizational factors that impact health equity work. Therefore, my two sub-questions are: *1) How do frontline public health staff understand and articulate the concept of health equity?* and *2) How do they articulate how relational and organizational factors impact their work on health equity?* My analysis focused on how frontline public health staff understand health equity and the organization they work for in order to elucidate the conceptual, relational and organizational dynamics at play over a time period of organization-wide change in the pursuit of health equity.

This project involved the analysis of qualitative data collected as part of the Equity Lens in Public Health (ELPH) project. ELPH examined the application of a health equity lens during the renewal of public health services in British Columbia – a period of complex public health system change (Pauly et al., 2013). ELPH sought to understand how equity figured in the implementation of a large-scale public health policy and program intervention and involved research questions related to the prioritization of health equity, intersectoral action on health equity, the use of health equity tools and ethical tensions in public health practice (Pauly et al., 2013).

The next chapter, Chapter 2, begins by defining health equity, discussing its importance to the field of public health and describing the existing literature on conceptual understandings of health equity as well as the implementation of health equity action within public health organizations. Chapter 3 continues by mapping out the research gaps and the research questions that guided this thesis project and then describing the theoretical framework, methodological approach and methods I used. Chapter 4, 5 and 6 contain the findings of my study. Chapter 4 discusses how frontline staff articulate the concept of health equity and Chapter 5 and 6 describe how they articulated the relational and organizational factors that impacted their health equity work. Chapter 7 compares my findings to existing literature, draws out some new theoretical insights, outlines the limitations of the work and concludes with implications for health equity practice, concepts and research.

Chapter Two: Literature Review

In this chapter, I provide an overview of how health equity is defined in public health, summarize existing literature on conceptual understandings of health equity and the implementation of health equity action, and outline my research question and the significance of this study.

Defining health equity

‘Health equity’, as a term, has come to represent a constellation of ideas and practices within public health, health care and beyond. It is often used to signify a number of related meanings. For the purposes of this thesis project, I highlight here two common understandings of health equity and what each understanding implies about what action ought to be taken.

The first understanding of health equity relies heavily on the concept of health inequities. According to this understanding, health inequities are differences in health status or outcomes that are unfair, unjust, and potentially alterable (Braveman, 2014; Braveman et al., 2011). Not all inequalities, or differences in health within a population, are inequitable (Arcaya et al., 2015). Inequities are unfair because they are produced by inherently unjust forces of social disadvantage, which render some of us better and some of us worse off (Whitehead & Dahlgren, 2006). The key here is that differences in health must also line up with unjust differences in social conditions for them to be recognized as inequities (Braveman, 2014).

The social production of inequities suggests that they are amenable to intervention (Whitehead & Dahlgren, 2006). Health equity, according to this understanding, guides us towards the reduction of inequities in health and in the social determinants of health (Braveman, 2014). This can be achieved by improving the social conditions of the most disadvantaged in society to bring them up to the level of the most advantaged, also known as ‘leveling up’

(Braveman et al., 2011; Whitehead & Dahlgren, 2006). The ultimate goal here is to eliminate inequities so that “everyone [can] attain their full health potential and that no one [is] disadvantaged from achieving this potential because of their social position or other socially determined circumstance” (Whitehead & Dahlgren, 2006, p. 5). A commitment to social justice, based on concepts of equality and human rights, is at the heart of scholarly definitions of both health inequities and health equity (Braveman et al., 2011).

This first understanding of health equity focuses on the social conditions that shape health and health inequities but does not specify what generates the “socially determined [circumstances]” (Whitehead & Dahlgren, 2006, p. 5) of people’s lives and health. In contrast, the second understanding of health equity highlights that social conditions are produced by some of society’s most enduring cultural, economic and political structures such as heteropatriarchy, neoliberal capitalism and racialized colonialism – the structural determinants of health – which rely on the inequal distribution of social power and material resources (Navarro, 2009; Ottersen et al., 2014; Reading & Wien, 2009; Scott-Samuel et al., 2015). The second understanding of health equity was brought into mainstream public health discourse with the publication of the findings of the World Health Organization’s Commission on the Social Determinants of Health, which explicitly named “the inequitable distribution of power, money, and resources” (Marmot et al., 2008, p. 2) as the key cause of health inequities and therefore as an essential target of health equity action.

Although both understandings rely on the concept of health inequities, the first understanding of health equity naturalizes inequities by not acknowledging their known root causes, whereas the second problematizes them by linking them to socially generated structures (Plamondon et al., 2020). Health equity action, according to the second understanding, would require recognizing the historical and present day violence and complicity of social structures and redistributing power, money, and resources to redress the impacts of these power relations (Heller et al., 2024; Plamondon & Shahram, 2024). The attention to power and the call to transform inequitable structures make this second understanding of health equity a critical one (Bowleg, 2017; Labonte et al., 2005; Lok, 2019); it is this structural and politicized understanding of health equity that I use in this thesis.

Health equity in public health

Although the term health equity has been gaining traction in Canadian healthcare, concepts underlying health equity have long been foundational to public health (Fairchild et al., 2010; Fee & Gonzalez, 2017; Yao et al., 2019). In public health, health equity is invoked in many ways, including as a concept, a value, an end goal or benchmark, and a way of working (Good, 2017; Plamondon & Shahram, 2024; Whitehead & Dahlgren, 2006). Terms like 'health equity lens', 'health equity tools' and 'health equity impact assessment' are proliferating in public health parlance and refer to paradigms, strategies and resources for promoting health equity (Pauly et al., 2016). These perspectives and supports are intended to help various actors pay attention to inequities in health produced by unjust social conditions in order to take action to decrease these inequities. Common foci for health equity action in public health include policy and practice. I understand policy as "a definite course or method of action selected" by a group or organization "from among alternatives and in light of given conditions to guide and determine present and future decisions" (Heller et al., 2024, p. 8). I understand practice as "the ways in which an [organization or group's] members carry out their functions and responsibilities, often through established patterns of behavior, procedures, and rules" (Heller et al., 2024, p. 9).

The history of the concept of health equity in public health can be linked to other similar concepts that attempt to center justice in the concepts and practices of the field. Social determinants of health theories and some health promotion models invoke the sense that power and resources are unequally and unjustly distributed among human beings, and that this affects our lives and our health (Irwin & Scali, 2007; Raphael, 2008). However, the potential positive impact of these concepts is muted when they are interpreted or applied in ways that depoliticize or remove a power and justice analysis from them (Asthana et al., 2013; Heller et al., 2024; Raphael, 2008, 2011).

Given that no other sector of the health system – or any social institution – in Canada is foundationally focused on the systemic causes of ill health and health inequities, it is essential that public health retain this focus (National Collaborating Centre for Determinants of Health, 2011, 2014).

Conceptual understandings of health equity

A number of conceptual frameworks related to health equity have been advanced in public health across Canada and internationally in the last 20 years. This development responds to calls from within the field to elaborate terms and concepts in order to develop a clear shared understanding of what health equity is and what public health can and should do about it (e.g., National Collaborating Centre for Determinants of Health, 2011).

Earlier writing on health equity worked to define what health equity is and is not and to map its philosophical and normative underpinnings (e.g., Anand et al., 2004; Pan-American Health Organization, 2001; Whitehead & Dahlgren, 2006). More recent work has focused on how public health organizations can ‘do health equity’ well. For example, the Organizational Capacity for Public Health Equity Action (OC-PHEA) conceptual framework describes the factors that contribute to a public health organization being able to take action related to health equity (Cohen et al., 2013). Similarly, Lambton Public Health in Ontario developed a framework and corresponding assessment tool that outlines the internal and external elements needed for an organization to drive local health equity action (Good, 2017). The Systems Health Equity Lens produced by the Equity Lens in Public Health project (of which this thesis is a part) uses a social ecological model and understandings of complex adaptive systems to map out the levels at which action is necessary to reorient health systems towards equity (Pauly, Shahram, et al., 2018). Other models have mapped out key factors for promoting health equity in ways that center particular population groups, such as Indigenous people (Kent et al., 2017) and LGBT people (Eckstrand et al., 2017).

Despite significant overlap in the elements contained in these models, how health equity is conceptualized by practitioners and decision makers on the ground is not homogeneous. Research has highlighted wide variation in what people think health equity is and how they translate it into practice (Brassolotto et al., 2014; McMahon, 2022; Pauly et al., 2017). Conceptions of health equity described in the literature in part differ in terms of how far upstream the underlying analysis of the problem of health inequity goes. Different definitions and causal frameworks for inequities differently imply who is morally and practically responsible for them and what is ideal and appropriate action (Lynch & Perera, 2017).

Given that structurally focused actions are more effective for reducing inequities and promoting health equity than ones that address social conditions but not their root causes (Heller et al., 2024; Lorenc et al., 2013; Macintyre, 2007; McCartney et al., 2013; Plamondon & Shahram, 2024), conceptual frameworks can directly impact the degree to which public health practitioners are able to effectively promote health equity in their work. For example, Rizzi (2014) found that among frontline staff in Ontario public health units, the dominant perspective was that health equity was about equal access to care, equal opportunity for health and equal social determinants of health. Most work that had an explicit goal of promoting health equity involved identifying and working with ‘priority populations’ who faced barriers to access.

Pauly et al. (2017) found similar themes in their study of public health leaders in BC. They found that participants understood health equity in three different ways: as increasing access to health services, promoting access to social and material determinants of health and focusing on vulnerable populations. Few participants offered an analysis of health equity that emphasized the need to shift structural factors (i.e., the institutions and systems that structure the distribution of social power and material resources) and there was a definite lack of acknowledgement of the health system itself as a source of inequity. The researchers found it was difficult for practitioners to talk about health equity, let alone advance coordinated action, in part because of differences in how health equity was understood.

In contrast, a study by Knight (2014) found that a group of public health and community leaders working to promote health equity at policy and practice levels had a more politicized understanding of health equity. This group saw justice as foundational to health equity and highlighted the need to shift attention away from downstream causes of inequity to its structural roots, including how power is organized in society. They saw the role of public health as catalyst and convener of intersectoral work and emphasized that health equity related research must be driven by community needs and value epistemic diversity.

Related studies have mapped a similar range of perspectives on the social determinants of health. A study by McIntyre et al. (2013) discovered that public health practitioners tended to understand the social determinants of health in terms of individual level problems and solutions instead of in terms of population level patterns and dynamics. They also found that practitioners did not include ideas about inequity in their understandings of the social determinants of health.

Some of the studies investigating understandings of health equity used the concept of ‘discourses’ – discrete, enduring and more or less coherent constellations of “ideas, attitudes, courses of action, beliefs, and practices” (Lessa, 2006, p. 285) that frame and delimit how people think and act (Talja, 1999). For example, Brassoloto et al. (2014) found that public health practitioners drew on a range of discourses when they tackled the intersections of health and social forces, ranging from a functional focus on priority populations to an analytical assessment of the impacts of social position on health to a structural emphasis on shifting the political causes of inequity. The authors contended that differing understandings of the social determinants of health did not prevent people from acting – everyone believed they understood the social determinants of health and they acted according to their understandings. However, the authors argued that the functional and analytical understandings created epistemological barriers to taking the kinds of action that addressed the structural roots of health inequities, thereby “[treating] health as individualized and depoliticized” (Brassolotto et al., 2014, p. 321). This study highlighted the important connections between conceptual understandings of health equity and effective health equity action.

Overall, the literature has found that understandings of health equity held by public health practitioners and leaders tend to skew downstream. McMahon’s (2022) meta-ethnography of how social inequalities are understood and tackled in health practice and policy (in public health and beyond) summarizes the literature well. The authors found that the dominant perspective on health equity focused on ‘disadvantaged’ groups who had ‘individual risk factors’ for health; the appropriate course of action was therefore to enable these groups to access health-promoting resources such as health care, healthy behaviours and the social determinants of health. A minority of participants understood health inequities to be caused by structural inequities produced by politics and policy and thus, fewer saw acting to affect these broader dynamics as within their purview. For public health practitioners and decision makers, understandings of health equity are dominated by ideas about individual and group access to services and the social determinants of health. Structural conceptions of health equity that understand the social distribution of power as a root cause of health inequities are underemphasized.

Taking health equity action

In my immersion in the literature for the purposes of this thesis project, I encountered two kinds of empirical qualitative research on public health practitioners' experiences of taking action to promote health equity. The first involves asking a particular kind of actor (e.g., senior leaders) in a particular organization (e.g., a public health department) or geographical area (e.g., a province) to describe their overall experiences of doing health equity work. This kind of research provides a general description of the experience of doing health equity work from a particular organizational standpoint. Quantitative research has also been published that takes this approach, such as studies that aim to identify the organizational factors that correlate with increased action on health equity (Shah & Sheahan, 2015; Yang & Bekemeier, 2013).

The qualitative research of this first kind of study that I included in this literature review found that despite the enthusiasm for health equity espoused by public health practitioners and leaders at many levels, there are numerous challenges to undertaking health equity work (Knight, 2014; McPherson et al., 2016; Narain et al., 2019; Sadare et al., 2020; Valaitis et al., 2016). Some have to do with the grand and complex scale of the problem – the social, cultural and economic structures that generate inequities (Raphael, 2015). Other challenges emerge from certain actors or organizational structures within the public health system itself, which I expand on below.

One significant challenge described in this body of literature is the tendency for both practitioners and decision makers to let their attention slip downstream to focus on increasing equitable access to services instead of upstream to the structural root causes of inequity. This tendency gives precedence to understandings that depoliticize health equity. However, this downstream shift partly the consequence of specific social and organizational ideas and institutional arrangements. For example, a bureaucratic emphasis on measurable outcomes and evidence-based practice, public pressure for better acute care and the strong tide of a biomedical culture means that concerted strategies are needed to keep refocusing one's gaze and action upstream (Asthana et al., 2013; McMahon, 2022; National Collaborating Centre for Determinants of Health, 2011; Orton et al., 2011; Pauly et al., 2021; Wildgen & Denny, 2020).

Other barriers to health equity action described in the literature include variation in conceptual understandings of health equity and the social determinants of health at both frontline and leadership levels, which leads to confusion about how to best approach the work (Brassolotto et al., 2014; Ngunangwa, 2016; Pauly et al., 2017). Practitioners can become overwhelmed by the huge scale and long-term nature of the problem and unsure about what they can do within their limited professional roles (McIntyre et al., 2013; Pauly et al., 2021) or morally distressed by contradictions between their own ethical commitments and the demands of the systems they work for (Pauly et al., 2021). Practitioners also struggle with knowing how to translate the concept of health equity into practice and how to adapt evidence to local contexts (Orton et al., 2011). A young and underdeveloped evidence base for interventions that promote health equity is often cited as a key challenge in a sector that deeply values detailed quantitative evidence to justify the use of particular strategies (National Collaborating Centre for

Determinants of Health, 2011). One evidence gap has to do with the implementation of health equity related interventions, particularly the individual, interpersonal and group contexts of implementation (Martin et al., 2016; Pauly et al., 2017).

The second type of qualitative study I explored for this research focuses on the implementation of particular context- and time-specific initiatives designed to promote health equity. These kinds of studies offer a unique window into how specific organizational contexts impact health equity ideas and action. Implementation studies might examine the organizational elements in place before implementation, the elements of the intervention and how the ways in which implementers dealt with emerging challenges affected the outcomes of the initiative and/or the experiences of those involved. Although there is a small but growing body of Canadian literature on program-specific public health interventions to promote health equity, given that my study focused on organization-wide health equity initiatives, I focus here on literature describing interventions that aim to shift practices across a whole public health organization or across multiple organizations within a jurisdiction such as a province.

A study by Hassen et al. (2017) examined how a mandate to focus on ‘priority populations’ in the revised 2008 *Ontario Public Health Standards* facilitated or inhibited action on health equity in six public health units. They concluded that the term ‘priority populations’ lacked clarity and was not explicitly linked to a health equity vision, making it difficult for practitioners to know how to act on the mandate, with multiple understandings of health equity gaining traction. They also noted that practitioners experienced tensions between the requirement for evidence-informed practice and the local needs of communities. However, the mandate catalyzed important new programs and ways of working and legitimized existing work on the social determinants of health.

McPherson et al.’s (2016) study of the creation of Social Determinants of Health Public Health Nursing positions in Ontario public health units identified some of the factors that supported and constrained this initiative. The study found that it was a challenge to have health equity work valued in the organization, as not all practitioners saw its importance, resulting in some resistance to the initiative, but that senior leadership support and commitment to social justice eased this. It also found that positioning and embedding health equity work across the organization instead of within a specific program area allowed health equity knowledge and practice to spread to different areas of the organization.

Sutcliffe et al. (2010) studied the role of health equity knowledge brokering in shifting practice in a public health unit in Ontario. Again, buy-in and support from top public health leadership was a key factor for success, as was a designated team that practitioners could draw on for expertise and support in translating evidence into action. Other organizational conditions that supported the work included a longstanding history of governance and structures created to work on health equity, dedicated financial resources and a high level of staff readiness and enthusiasm. As in the Hassen et al. (2017) study above, the project team faced challenges related to using evidence for local practice.

A study by Sadare et al. (2020) looked at the use of Health Equity Impact Assessments (HEIAs) in a public health unit in Ontario. All 23 programs within the organization were required to conduct at least one HEIA on a policy, program or service in order to identify possible unintended impacts on a priority population. The HEIA process resulted in program-level changes such as enhanced collaboration and the removal of barriers to services, although the impact of these changes on priority populations was not measured. The authors found that the mandate to conduct HEIAs came with dedicated resources and leadership support, both of which facilitated change. Strategies for data collection, skilled staff and strong internal and external collaborative relationships also supported this work. A lack of resources, support and data posed barriers to implementation.

Interestingly, both kinds of studies on health equity work have generated research reports that pay significant attention to the factors that make health equity work easier or harder. This very practical reporting on the barriers and enablers of action seems to be a recent preoccupation in public health research on health equity. Within Canada, the majority of studies looked at for this thesis have been conducted either nationally or in Ontario.

Research gaps and research question

This thesis project on how frontline public health practitioners in Canada engage with health equity emerges from a few gaps in the existing literature on health equity in public health. Although most published implementation studies focus on a specific program within a particular area of public health programming, system- or organization-wide health equity initiatives such as those in the studies described above are becoming more common in Canada (e.g., Kouri, 2013; Mador, 2010) and thus should be studied further. Given that "addressing health determinants to reduce health inequities potentially involves every aspect of how an organization operates" (National Collaborating Centre for Determinants of Health, 2011, p. 24) it is useful to examine how various organizational elements support or challenge the promotion of health equity. What organizational factors enable public health organizations – and the actors connected to them – to make an impact on inequities, and where might organizations be in the way of movement towards health equity?

Much of the literature I reviewed above emphasizes that the buy-in of leaders is essential for making substantive shifts in how issues are prioritized, programs are designed, resources are allocated, and staff are held accountable for focusing on health equity (Good, 2017; McPherson et al., 2016; National Collaborating Centre for Determinants of Health, 2011, 2014; Sutcliffe et al., 2010) affirming that the organizational context influences the experiences of public health practitioners. Of course, health equity related action is usually implemented within the context of large public sector organizations and therefore focusing on leaders recognizes that hierarchical organizational power is a materially important factor in this context. Some health equity frameworks, however, recognize that practitioners at all levels of a public health organization have agency within the institutional environment and are important to an organization's overall capacity for health equity action (Cohen et al., 2013). The understandings and actions of frontline public health staff, who are ultimately responsible for the implementation of many organization-wide change initiatives, are key to their success or failure (Pauly et al., 2017; Tomm-Bonde et al., 2013; Valaitis et al., 2016).

Despite previous research that has hinted at how conceptual frameworks of health equity and the social determinants of health likely translate into action (e.g., Brassolotto et al., 2014; Raphael, 2011), there is only a small body of research on how practitioners – especially frontline practitioners – navigate a range of factors, from the individual to the organizational, and how these factors might interact in their work to promote health equity.

Some of the studies reviewed above describe how the logics, norms, and relationships of a complex organizational context shape how health equity values, concepts and tools are taken up, both in conceptual frameworks and in practice (Cohen et al., 2013; Good, 2017; McPherson et al., 2016; Orton et al., 2011; Sutcliffe et al., 2010). However, studies that investigate the health equity initiatives in public health using organizational theory (which I define below) are limited. Given the predominant role of the organizational context in shaping the way health equity work is done, this is an exciting point of departure.

My main research question for this thesis project was: How do frontline public health staff engage with health equity during a time when the organization they work for has declared health equity an organizational priority? To investigate both conceptual understandings of health equity and how the organizational context shapes action on health equity, my two sub-questions were: 1) How do frontline public health staff understand and articulate the concept of health equity? and 2) How do they articulate how relational and organizational factors impact their work on health equity? For each sub-question, I explored how the articulations of health equity and the factors impacting health equity changed over the period of study. My questions focus on the experiences of frontline practitioners as they navigate health equity within their specific organizational context.

Significance of the research

My research question had the practical goal of expanding understandings of how health equity work is done in public health organizations. Particularly at a time in which more health systems are choosing to implement organization- or system-wide health equity interventions, my research aimed to help illuminate the benefits and challenges of such interventions by assessing how they interact with the work of frontline staff – those people who are primarily responsible for carrying out public health work. My research may give frontline staff guidance for how they might navigate the multiple factors that affect their work, and may give senior decision makers ideas for creating organizational initiatives that effectively support staff to promote health equity.

My hope is that this work will contribute to painting a more comprehensive and nuanced picture of the interplay between public health organizational systems and the people connected to them. It may also help us better understand the potential and the limitations of using health equity as a value, concept and practice for pursuing justice in public health and beyond.

Chapter Three: Methods

In this chapter, I outline the theoretical framework on which my research is based, the study design and the study methods.

Theoretical framework

A critical poststructural epistemology

This project is, at its foundation, grounded in a personal commitment to critical scholarship, that is, research that recognizes and interrogates how social power produces inequitable and oppressive relations of domination and that aims to illuminate ways to transform these unjust arrangements (Bowleg, 2017; Labonte et al., 2005; Lok, 2019).

This commitment emerges in part from my social location as a queer disabled woman of colour with recent family history of migration and settlement on Turtle Island. Professionally, I locate myself as a researcher and community builder who has worked primarily in community, public and non-profit sector environments. Specific to this study, I have never worked in the BC public health system, although I currently work in a non-frontline position in public health in Nova Scotia. I therefore bring a mostly outsider perspective to this project.

My research question begins by focusing on a specific relation of domination, namely, the inequitable distribution of social and economic power and resources and thereby health according to specific social patterns – health inequity. This configuration of power is fortified by social, cultural, economic and institutional structures, which often resist attempts to challenge them that are based on ethical frameworks of justice (J. M. Anderson et al., 2009). Examples of resistance to justice-based challenges within the sphere of public health include the tendency of public policy and service provision to focus on medicalized or behavioural interventions that do not address the social determinants of health inequities, let alone the causes of the causes of health inequities such as economic arrangements like capitalism (Baker et al., 2017; Navarro, 2009; Raphael, 2015).

A critical approach also draws attention to relations of power in public health organizations, specifically, the corporate hierarchy in which frontline staff have some of the least organizational power and senior leaders have some of the most. These particular relations of power might fortify or challenge health inequities, and public health practitioners' descriptions of how these hierarchical dynamics variously enable and constrain health equity action that I reviewed in Chapter 2 suggest that the picture is complex.

My commitment to interrogating and challenging relations of domination is supported by a poststructural understanding of power. In contrast to a structuralist approach to power, which asserts that the "rules and mandates" (the structures) of institutions and organizations fully determine actors' ideas and behaviours, a poststructuralist approach sees power as dispersed among actors, which means that even actors with the least organizational power have agency to think and act in ways that contradict and sometimes substantively challenge domination (Harris et al., 2020, p. 549).

Using a critical poststructural epistemological frame in this study allowed me to combine a critical commitment to challenging unjust relations of domination with a poststructural understanding of power, resulting in the assumption that although the structures of organizations influence (and sometimes perpetuate) unjust power relations, every actor connected to these organizations has some measure of agency to influence (including to challenge) these relations. It was my goal in this project to identify some of these configurations of power and explore how they relate to each other.

A discursive approach

In order to make visible some of the relations of power influencing frontline staff's experiences of doing health equity work, I chose to pay attention to ideas. Ideas are a key element in the operation of power – they constitute some of the "rules and mandates" of organizations as well as the "values and interests" of actors (Harris et al., 2020, p. 549). Often, the term 'discourse' is used to "capture the substantive content of ideas – 'core beliefs' – as well as the practices and processes through which ideas are conveyed and communicated (or not communicated) in institutions and by actors" (Harris et al., 2020, p. 549). Discourses are relatively enduring and coherent formations of knowledge that are often based on unspoken assumptions or theories about 'the way things are' and 'the way things work', which produce a particular limited angle from which to approach a topic (Talja, 1999). Generally, more than one discourse exists on a particular topic at a particular point in time, even within a single person (Talja, 1999).

Discourse operates primarily through language, although it also has material aspects related to bodies, objects, spaces and practices (Hardy & Thomas, 2015; Lessa, 2006). The central theoretical premise of a discursive approach to research is that language – including in the form of talk or written text – reflects and creates actors' experiences of reality. Talk cannot be taken as a truthful representation of reality; instead, talk is a productive act of interpretation. When speakers speak about a thing, they produce the reality of the thing about which they speak. This also means that by speaking, speakers have a certain power to construct and produce reality. Thus, the meanings of things are never singular or fixed but can be multiple and are always in a process of becoming. By paying attention to language, one can identify how speakers organize their understandings of and engagements with the world. Discourses are a useful unit of analysis because they allow researchers to trace which ideas about a phenomenon might be more or less dominant in a particular context.

Discourses, as formations of knowledge that address a topic from a limited angle, in turn shape ideas and action. Certain discourses will shape ideas and action in certain ways; other discourses will shape ideas and action in other ways. A discursive approach therefore, allows one to “point out the power and influence of particular narratives and to analyze their potential societal and institutional functions and effects” (Talja, 1999, p. 474). Discourse can therefore be a useful analytic tool to make relations of power and domination visible, as it draws attention to how ideas work in specific contexts to either fortify or challenge power. In the case of my study, I hoped that identifying the discourses in circulation among frontline public health staff about the concept of health equity and the relational and organizational factors influencing their health equity work would shed light on the ideas and therefore the relations of power that that impacted their work. Therefore, my analytic goal was to identify the discourses present in frontline staff’s talk (i.e., their language) about health equity and to elaborate how these discourses related to the material and social realities of the organizational context in which they worked. To do this, I used an analytic method called Critical Thematic Analysis, which I explain in the Study Methods section below.

I also chose a discursive approach because of my interest in the conceptual scope and practical possibilities of health equity, including what kinds of ideas and actions the concept of health equity does and does not make possible. By starting with language, I was able to identify the discourses that enabled frontline staff to understand health equity and their organizational context from particular angles and examine how those perspectives foreclosed other alternative understandings and actions. Investigating these perspectives is important, given the point I made in Chapter 2 that certain actions are more effective than others for reducing inequities (Lorenc et al., 2013; Macintyre, 2007; McCartney et al., 2013).

Discursive approaches have been applied to other public health concepts such as the social determinants of health (Raphael, 2011) and health promotion (Purkis, 1997) and researchers have argued that paying attention to discourse is important in the study of health equity, specifically because how practitioners and policy makers conceptualize health equity impacts their action (Brassolotto et al., 2014; Lynch & Perera, 2017; Raphael, 2011). Using a discursive approach complemented existing ELPH research products that described how health leaders talk about health equity (Pauly et al., 2017) and how Indigenous health equity can be conceptualized using culturally specific language, metaphor, image and word (Kent et al., 2017).

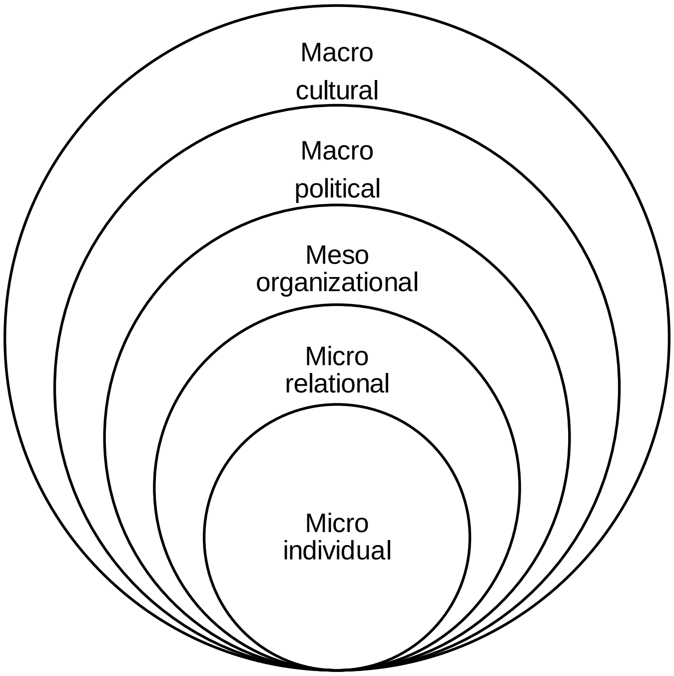
An organizational approach

Golden and Wendel (2020) have argued that a social ecological approach that attends to multiple levels – the micro levels of individual and relational ideas and action; the meso levels of community, organizations and institutions; and the macro levels of politics and culture – is important to understand the success or failure of attempts to move health equity from theory to practice. Relations of power operate at social and institutional levels but also at organizational, relational (interpersonal) and individual levels (Alvesson & Deetz, 2006). These forms of power are always interlinked and often mutually supportive. To draw explicit attention to these multiple levels and the relationships between them, I incorporated an organizational approach into my theoretical framework.

Figure 1 illustrates how I conceptualized the levels of context shaping frontline staff's experiences with health equity. The framework integrates the social ecological model commonly used in public health (adapted from Golden & Wendel (2020)) and the micro-meso-macro framework sometimes used in organizational theory (Macfarlane et al., 2013) to allow for

Figure 1:

An organizational approach to my research



linkages between the two disciplines and theoretical approaches.

Organizational theory comes primarily from the fields of management, sociology and political science. Theories of organization have as their central focus the structures and processes of organizations (Roness, 2018). Some theories might take up organization-wide questions about how organizations are formally structured, the norms and values espoused by organizations or how organizations make decisions to achieve certain outcomes. Other theoretical approaches such as organizational behaviour focus on more micro and meso level phenomena such as the decisions, identities, relationships and ethics of individuals or groups within the organization.

The use of organizational theory to examine health care is not new, with research applying this theoretical approach to health systems starting in the 1960s (Flood & Fennell, 1995; Mick et al., 2014; Scott, 1966). A number of organizational theories have been used to study factors impacting system-wide practice changes in health care (Javanparast et al., 2018; Macfarlane et al., 2013; Reay & Hinings, 2005; Sherer et al., 2016). Researchers have used theories of organizational behaviour to examine how to organize employees, work and practices to, for example, improve quality and patient safety, reduce workplace stress, address workforce shortages and promote complexity thinking among workers (Cartwright & Cooper, 2014; Cunningham & Geller, 2008; Lowman & Harms, 2022; Zucca et al., 2021). In the public health policy realm, organizational theories have helped to explain why certain strategies to promote health equity such as mandates and targets for health equity, the use of evidence and intersectoral action on health have experienced stagnancy or movement (Baum et al., 2017; Holt et al., 2018; Liverani et al., 2013; Warwick-Giles et al., 2017).

Organizational theory has significant potential to advance empirical work within public health, and in the case of this project, to study how the interactions that take place in specific kinds of organizational environments impact health equity related change. Specifically, it allowed me to map where and how power, structure and agency work to impact actors. This project follows a growing trend in organizational health research of focusing on the micro and meso levels of health care organizations (Macfarlane et al., 2013). Organizational theory's focus on context and systems also aligns well with the Equity Lens in Public Health study's approach of seeing public health as a complex adaptive system (Martin et al., 2016).

I started this thesis project using a slightly different theoretical approach to the study of organizations: discursive institutionalism. Discursive institutionalism sits within the tradition of institutional theory, which takes up as one of its questions why and how institutions stay relatively stable over time as well as why and how they change. Discursive institutionalism examines "how, when, where, and why ideas and discourse matter for institutional change, and when they do not" (Schmidt, 2010, p. 21). Discursive intuitionalism draws attention to how people understand various ideas related to a particular issue and how they use their communicative abilities for the purpose of collective action (Schmidt, 2012; Zurnic, 2014). The approach has been used to study health care and public health (Abeysinghe, 2012; Kirkland & Raphael, 2018; Stassen et al., 2010, 2013; Stucki, 2017).

However, as I conducted my analysis, I found that my inquiry was better served by theories of organizational behaviour, which are anchored in the identities of and relationships between actors within an organizational context, instead of institutional theory, which tends to study whether and how discourses impact the decisions and identities of whole or multiple institutions. My research was interested in the discourses among frontline staff that described their everyday practice, not how these discourses were implicated in whole-organization decisions or identities. Therefore, I realized that institutional approaches were not the most appropriate for my study. I also became aware of critiques that discursive institutionalism, which looks at "how, when, where, and why ideas and discourse matter for institutional change, and when they do not" (Schmidt, 2010), is incompatible with poststructural understandings of discourse, which assert that discourse *always* matters in organizational arrangements (Rönnblom & Bacchi, 2011). Therefore, I shifted my theoretical framing from discursive institutionalism to organizational behaviour.

Study design

Equity Lens in Public Health

In 2005, the BC Ministry of Health launched the renewal of the BC public health system with the new *Framework for Core Functions in Public Health*. Based on the premise that "public health needs to be better structured and resourced in order to improve the health of the population” (Ministry of Health Services, 2005b, p. 2), the framework outlined the core areas of programming that each health authority was required to offer the public. It also introduced two lenses that were to be applied to all programs and services – the Population Lens and the Inequalities Lens (later referred to as the Equity Lens). The Core Functions documents directly linked health inequalities to the “social, economic, cultural, and environmental determinants of population health” and noted that health authorities could work to decrease inequalities through research, community development, public policy advocacy or by “[ensuring] that those in greatest need of public health services, or those most vulnerable or at-risk, receive more attention” (Ministry of Health Services, 2005a, pp. 48–49). Evidence reviews were conducted for each core program area and one was also conducted for the Equity Lens (Pedersen et al., 2007).

The Equity Lens in Public Health (ELPH) was a program of research that investigated health equity in BC’s public health system. The study was designed to investigate the use of an equity lens during this time of restructuring of the public health system. Public health renewal in BC therefore functioned as a natural experiment in the implementation of system change oriented toward health equity (Pauly et al., 2013). ELPH consisted of four studies that posed interrelated research questions. Findings from all four studies have illuminated factors supporting the organizational prioritization of health equity, ethical tensions inherent in doing health equity work, understandings of health equity among health leaders, health equity tools and specific frameworks for Indigenous health equity (Kent et al., 2017; Marcellus et al., 2022; Pauly et al., 2017, 2021; Pauly, Martin, et al., 2018; van Roode et al., 2020).

ELPH Study 1, within which this thesis project is nested, looked at the prioritization of health equity and the strategies proposed and implemented to achieve it across five health authorities and one provincial health services authority in BC. ELPH Study 1 used a comparative case analysis design to look at multiple cases, each case being one of the six health authorities in BC. The research team undertook cross-case comparisons as well as within-case analysis at baseline and follow-up using content and critical discourse analysis. The final research products for Study 1 included the papers mentioned above as well as a series of knowledge translation products that included practical resources for enhancing health equity in systems, a BC case study, a situational analysis of the application of a health equity lens and a framework to promote systems level health equity (Equity Lens in Public Health, 2019).

Longitudinal qualitative approach

My research question was interested in the factors that impacted frontline practitioners' experiences with and negotiations of health equity in a particular organizational context, but given that ELPH investigated health equity over a period of organizational change, I also wanted to draw attention to change over time.

Therefore, I used a longitudinal qualitative approach to analyze data collected at multiple time points. Longitudinal qualitative analysis is becoming increasingly popular in health services research as a way of understanding the dynamics of change over time (Grossoehme & Lipstein, 2016). Specifically, I used what Grossoehme and Lipstein (2016) call recurrent cross-sectional analysis, which looks at changes at the level of a whole study sample, as opposed to changes at the level of an individual or family unit. Recurrent cross-sectional analysis is often used to compare two time points (for example, before and after the implementation of a change) or when maintaining a cohort is not possible over multiple time points (Grossoehme & Lipstein, 2016), both of which applied to this project.

Study methods

Data collection instruments

The ELPH team worked collaboratively with research partners from the BC public health system to develop the research questions for Study 1, design the study and create the semi-structured interview guide. The interview guide aimed to generate data relevant to many areas of the ELPH project but the questions most relevant to my project are below in Figure 2. The same questions were asked at two time points, Phase 1 (conducted in 2014) and Phase 2 (conducted in 2015). Information was also collected about each participant's gender, age, years in their position, years in public health, and highest educational qualification.

Ethics approval was secured from the University of Victoria and the relevant health authority through a harmonized research ethics board (protocol number H11-03359) before data collection commenced. Ethics permissions were extended to me for the purpose of secondary analysis.

Sampling and data collection

To recruit participants, health authority leaders in public health manager and/or director positions sent emails to invite frontline staff to participate in focus groups. Data collection was conducted by region, which meant that participants in each focus group generally knew each other and worked together in the same public health unit, although they might work in different locations or public health programs. This also meant that the same public health unit and/or the same participants may have participated in both phases of data collection.

To make the study scope manageable, ELPH chose to focus on the application of an equity lens in two core program areas only, mental health promotion/prevention and preventing the harms of substance use (Pauly et al., 2013). Although the study team initially focused on recruiting participants who only worked in these two areas, they found that frontline staff who worked in mental health and substance use also delivered a range of other programs in areas such

Figure 2:

Interview/focus group questions relevant to my research question

Public health work and health equity

1. Tell me about your work, and how it contributes to promotion of health equity, or reducing health inequities?
    - What kinds of things do you do to promote health equity in your work?
    - What percentage (if any) of your work is devoted to health equity?

Meaning of health equity

2. How do you understand health equity?
3. How is health equity understood in your department? In your organization?
4. Where or when is the term “health equity” discussed?

Priority setting and health equity

5. What would you say are priorities for you in your work?
6. What are the priorities are in your program or department?
7. In your opinion, to what extent would you say health equity is a priority for you? Your department? Your organization?
8. What would you say has influenced the development of particular priorities for you, your department, your organization?
    - What facilitates making health equity a priority?
    - What are the challenges in making health equity a priority?

Health equity goals and strategies

9. What goals if any does your department have related to health equity promotion or reduction of health inequities? What about organizational goals?
10. What strategies does your department have in relation to health equity? Your organization?
11. What do you think has influenced the development of health equity goals and strategies for you? your program or department? Organization?
12. What do you see as the future directions in the promotion of health equity and reduction of health inequities for you? Your department? The organization?

Evidence and evaluation

13. What evidence are you aware of in relation to health equity? e.g., measurement of inequities, best practices?
14. What evidence do you draw on in your practice related to health equity or health inequities?
15. How, if at all, does your health authority measure and monitor progress in reducing health inequities? Evaluate progress?

as maternal-infant-child and Indigenous health. In many cases staff delivered mental health and substance use services through those other programs. Therefore, focus group discussions covered a range of program and service areas.

For my secondary analysis of ELPH Study 1 data, I selected one of the five regional health authorities in BC. I selected one regional health authority to ensure the scope of the study was reasonable and feasible for a Master’s thesis. I chose the health authority for which the greatest number of focus groups and interviews had been conducted with frontline staff, in the hope that my findings would paint a comprehensive picture of the experiences of this group of participants.

Individual interviews and focus groups were conducted in two phases, the first in 2014 (which included a pilot interview conducted in 2012) and the second in 2015. Phase 1 involved five focus groups and one interview with 35 participants and Phase 2 involved nine focus groups and one interview with 64 participants, for a total of 14 focus groups and two interviews with 99 participants. Focus groups/interviews were conducted by members of the ELPH research team face-to-face or by phone, were audio recorded and took 30-100 minutes each. Written consent was obtained from all participants before the interviews and focus groups began.

Data processing

Audio recordings were transcribed verbatim by experienced transcriptionists and reviewed by members of the research team for accuracy. Participants were given a participant number and organization names were replaced with pseudonyms.

Given that this thesis project was a secondary analysis, I began my analysis by reading through transcripts and listening to audio recordings of all focus groups/interviews to become familiar with the content. As I listened to the audio recordings, I noted my initial thoughts about possible codes and analytic ideas in the transcript margins (Braun & Clarke, 2006). Listening to the audio recordings in addition to reading the transcripts helped me to pay attention to non-verbal utterances (e.g., laughs, exclamations) and features of speech (e.g., emphasis, pauses) as well as dynamics between participants (Szabo & Strang, 1997). I added notations to the transcripts to indicate emphasis, laughter or other expressions of emotion, pauses and vocal tone.

Report on the organizational context

After familiarizing myself with the data, I reviewed selected documents collected by the ELPH team to begin to sketch out the organizational context, including the contexts of the BC public health system and the regional health authority on which my study focused. This review also allowed me to familiarize myself with the ideas and language being used in BC public health policies related to health equity. To begin, I reviewed two documents related to the *Framework for Core Functions in Public Health* (Ministry of Health Services, 2005a, 2005b) as well as *BC's Guiding Framework for Public Health* (Province of British Columbia & Ministry of Health, 2013; revised in 2017).

From this review, as well as from discussions with ELPH project team members, I created a short report describing the organizational context before and during the time range of data collection (Mills et al., 2010). This report included descriptions of the BC public health system, the process of public health renewal and a timeline of events relevant to the implementation of frameworks. I chose the time range of 2005-2015 for my report because 2005 marked the release of the Core Functions Framework and the second phase of study data was collected in 2015. I hoped the report would anchor my analysis in the specific time-bound organizational context of the health authority, assist me to identify changes between Phase 1 and Phase 2 and potentially identify organizational factors that might be linked to those changes. The report, with details removed that might identify the health authority I selected for my analysis, is included in the Appendix.

Data analysis

I chose a method of data analysis that would allow me to use both a critical and discursive approach. Critical Thematic Analysis (CTA) allowed me to examine the connections between the micro level ideas and relationships of frontline staff, the meso level organizational environment and macro level cultural, economic and political structures. Lawless and Chen (2019) outline a method for conducting CTA on interview text that aims to identify discourses and their relationships to macro structural forces of domination. Their approach to CTA offers a concrete way for researchers with critical scholarly commitments to analyze qualitative data. Lawless and Chen's analytic steps for doing CTA are based on guidelines for thematic analysis outlined by Braun and Clarke (2006); my data analysis process drew on both these methodological approaches.

Lawless and Chen's method consists of two steps in the coding process. First, the researcher performs open coding on the data to reveal patterns of language in order to identify discourses within and across individual accounts. Open coding is a step in qualitative analysis in which the researcher examines, compares, conceptualizes and categorizes the data in order to generate possible interpretations (Böhm, 2004; Starks & Brown Trinidad, 2007). In open coding, the emphasis is on closely honouring what participants said instead of applying a priori concepts that might prematurely shape interpretation (Böhm, 2004). Second, the researcher performs closed coding to link discursive patterns found in the data to larger social ideologies and power relations. In both steps, the researcher pays attention to repetition, recurrence and forcefulness of certain words, phrases, patterns of speech and ideas to identify dominant discourses (Owen, 1984). Together, these two steps allow the researcher to conduct a "critical reading of interview data that asks why and how communication codes are recurrent, repeating, and forceful in ways that reproduce and reinforce social inequalities” (Lawless & Chen, 2019, p. 95). CTA allowed me to critically identify discourses of health equity, relationship and organization in order to elucidate their links to each other and to larger social structures of power that produce health inequities.

Recurrent cross-sectional analysis involves analyzing each time point as if it were an individual study and then conducting a second analysis of the similarities and differences between the time points (Grossoehme & Lipstein, 2016). Therefore, I began by analysing Phase 1 data.

I started by open coding three Phase 1 transcripts that I found to be rich and quite different from each other in order to generate a broad range of codes. I coded these three transcripts by hand in order to encourage myself to stay close to the data instead of prematurely settling into a coding scheme. I coded using sensitizing concepts from the literature on health equity work, including action/inaction on health equity, barriers and enablers of action, discourses and language related to health equity, prioritizing of health equity goals and strategies, health equity knowledge and how health equity work is located and positioned in the organizational context.

Open coding resulted in a codebook of over 150 codes, which I refined to 41 by prioritizing codes that directly addressed my research question and provided important organizational and wider context. I transferred my hand-written codes to NVivo 10 and coded the remaining Phase 1 transcripts using my refined codebook, adding new codes where necessary. I then went back and recoded the first three transcripts using the updated codebook. I then worked to sort and organize the Phase 1 codes into broader overarching themes, creating diagrams and lists of themes and sub-themes (Braun & Clarke, 2006). At this point I began to identify distinct discourses and the relationships between them.

Lawless and Chen’s second step, closed coding, involves examining the coded data in relation to larger structures of power and ideology. In this step I examined how the discourses I found operating at the micro individual, micro relational and meso organizational levels were related to macro structural forces. I used the following questions to guide me in this step:

> “How are everyday discourses enabled and constrained by social systems, dominant ideologies, and power relations? How do macro- and micro-level discourses, practices, and systems intersect and reproduce dominations and oppressions? How can individual subjects become aware of dominant ideologies and work toward challenging them and promoting social justices?” (Lawless & Chen, 2019, p. 97).

I performed the same coding and theme generation process on Phase 2 data. During open coding, I created a new codebook in order to draw out the differences between phases. The Phase 2 codebook loosely paralleled the structure of the Phase 1 codebook but added additional ideas and elements and refined and reframed concepts from Phase 1. Analysis for Phase 2 was more complex than for Phase 1, as time-related observations began to emerge during the coding and theme generation processes (Grossoehme & Lipstein, 2016). I then sorted and organized Phase 2 codes into overarching themes using diagrams and lists as well as loose written narratives. These overarching themes contained a number of discourses as well as smaller themes that described elements of or interactions between the discourses.

I then examined the themes from the two phases side by side to identify which had changed and which had not. I used sequential matrices to visually map the findings, listing themes on the y-axis and the two phases on the x-axis (Grossoehme & Lipstein, 2016). This approach allowed me to track patterns in discourses and organizational context as well as the relationships between the two in order to produce themes that described the whole dataset. Once I created a draft thematic matrix, I used guidance from Braun and Clarke (2006) to review, define and name the discourses and my overarching themes.

I then began writing up my findings from both phases together, noting where there were interesting or no changes between the two phases. Early in the writing process, I reread the entire dataset to ensure that the discourses and themes accurately described the data. This led to a useful restructuring and filling out of my findings. I further refined and reorganized the discourses and themes throughout the writing process, relying on conversations with my co-supervisors, reading and reflecting on literature and elapsed time between stages of analysis to allow me to see the data in new ways.

Strategies for rigour

To enhance the rigour of my research, I used debriefing, auditing and attention to contradictions. I met regularly with my co-supervisors – one of whom was on the original ELPH study team and collected much of the data that I used in my analysis – as I developed my interpretations. This co-supervisor was able to confirm that my analysis fit the data, and that my findings echoed and expanded on those of other ELPH studies. I took detailed notes about my process of analysis and kept a personal journal throughout the study that allowed me to develop my findings, explore alternate possibilities for interpreting the data, think about how my positionality and ethical commitments impacted my conclusions, and reflect on the meaning and significance of my findings. I also intentionally looked for contradictory or discrepant perspectives in the data to ensure that my findings encompassed the data – this strategy helped me think deeper about the data, strengthen my analysis and add new themes to enrich my findings.

Overview of the following chapters

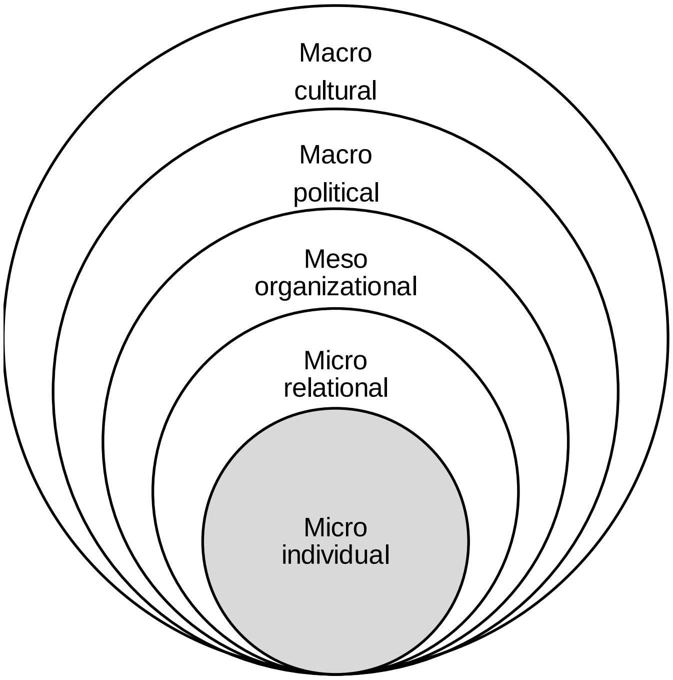
In the following three chapters, I present my findings. Each chapter answers a part of my overall research question: *How do frontline public health staff engage with health equity during a time when the organization they work for has declared health equity an organizational priority?* The next chapter, Chapter 4, focuses on individual level factors to answer the question: *How do frontline public health staff understand and articulate the concept of health equity? How does this change over the period of study?* Chapter 5 and 6 respectively consider relational and organizational levels to answer the question: *How do frontline public health staff articulate how relational and organizational factors impact their work on health equity? How does this change over the period of study?* Chapter 7 discusses my findings in relation to the literature and elaborates possible implications of the findings as well as limitations of the study.

Chapter Four: The Concept of Health Equity

Chapters 4 to 6 contain the findings of my thesis. I will begin Chapter 4 by describing the study sample. In order to answer the first part of my research question – *How do frontline public health staff understand and articulate the concept of health equity and how does this change over the period of study?* – I will identify and describe the key discourses present in frontline staff's (FLS's) talk about their health equity work, and discuss how these discourses changed from Phase 1 (2014) to Phase 2 (2015). This chapter focuses on discourses that concern factors at the micro level of the individual (the shaded element in Figure 3) – FLS's ideas, beliefs and attitudes about the concept of health equity. In Chapter 5, I will discuss discourses related to the micro level of FLS's relationships and in Chapter 6, discourses related to the meso level of the organizational environment, explaining how these discourses related to FLS's work on health equity.

Figure 3:

This chapter focuses on discourses that refer to the micro individual level of FLS's context



Sample description

All of the study participants were women. Most were between 30-60 years of age and had a Bachelors level education. These demographics did not differ substantially between phases. Phase 1 participants had worked an average of 12 years in public health and 9.3 years in their current position. Phase 2 participants had on average been in public health for 7 years and their positions for 6.6 years – less time than Phase 1 participants. Overall, participants in the whole study sample had worked an average of 8.8 years in public health and 7.6 years in their current positions. Only one person participated in both Phase 1 and 2 focus groups. Sample characteristics are included in Table 1.

Table 1:

Characteristics of the sample

Characteristic	Phase 1 (2014) (n=35)	Phase 2 (2015) (n = 64)	Both phases (n=99)
Gender			
Woman	35 (100.0%)	64 (100.0%)	99 (100.0%)
Age in Years			
< 30	3 (8.6%)	5 (7.8%)	8 (8.1%)
31-45	20 (57.1%)	27 (42.2%)	47 (47.5%)
46-60	11 (31.4%)	30 (46.9%)	41 (41.4%)
> 60	1 (2.9%)	1 (1.6%)	2 (2.0%)
Missing	0 (0.0%)	1 (1.6%)	1 (1.0%)
Years in Position			
< 1	2 (5.7%)	24 (37.5%)	26 (26.3%)
1-5	7 (20.0%)	16 (25.0%)	23 (23.2%)
6-10	16 (45.7%)	13 (20.3%)	29 (29.3%)
11-20	6 (17.1%)	4 (6.3%)	10 (10.1%)

Characteristic	Phase 1 (2014) (n=35)	Phase 2 (2015) (n = 64)	Both phases (n=99)
> 20	3 (8.6%)	7 (10.9%)	10 (10.1%)
Missing	1 (2.9%)	0 (0.0%)	1 (1.0%)
Years in Public Health			
0	0 (0.0%)	1 (1.6%)	1 (1.0%)
< 1	0 (0.0%)	14 (21.9%)	14 (14.1%)
1-5	4 (11.4%)	20 (31.3%)	24 (24.2%)
6-10	16 (45.7%)	17 (26.6%)	33 (33.3%)
11-20	9 (25.7%)	7 (10.9%)	16 (16.2%)
> 20	5 (14.3%)	5 (7.8%)	10 (10.1%)
Missing	1 (2.9%)	0 (0.0%)	1 (1.0%)
Highest Educational Qualification			
Diploma or Certificate	0 (0.0%)	3 (4.7%)	3 (3.0%)
Bachelor	30 (85.7%)	56 (87.5%)	86 (86.9%)
Masters	3 (8.6%)	4 (6.3%)	7 (7.1%)
Other	0 (0.0%)	1 (1.6%)	1 (1.0%)
Missing	2 (5.7%)	0 (0.0%)	2 (2.0%)

Participants described working in a range of public health areas, including but not limited to the ELPH study target areas of mental health promotion and the prevention of harms of substance use. Many participants worked in maternal, infant and child services, which included pre- and postpartum care and early childhood development support. A smaller number worked with school health programs such as youth clinics, doing immunizations or offering sexual health and harm reduction services to students. Others provided outreach services to adult populations or did communicable disease management. A few worked in or with Indigenous communities to deliver community-based public health services or to connect these communities to mainstream public health care. Very few described doing community development or public policy work.

Although most mental health promotion and harm reduction work was done within other programs such as perinatal care, a few participants specifically ran mental health or harm reduction programs. Participants were asked to introduce themselves at the start of each focus group, and three-quarters of those who identified their professional role were public health nurses. The rest were paraprofessionals, allied health professionals or administrative staff. Paraprofessional in this context refers to “workforce members who generally do not have formal professional or advanced educational training in health and/or human services but have some degree of specific training, such as promoting access to health information and resources and/or helping clients navigate a service system” (Rusch et al., 2019, p. 273). Although the study recruited for frontline staff only, three focus group participants were managers.

Overview of discourses related to the concept of health equity

In my analysis, I identified six micro individual discourses at work in FLS’s talk about the concept of health equity. I identified two discourses about the position of health equity in FLS’s practice: 1) health equity is a high priority and 2) health equity is implicit. I also found four discourses that articulated the meanings of the concept of health equity among FLS: 1) health equity is about access to services, 2) health equity is about vulnerable populations, 3) health equity is about individual needs and 4) health equity is structural. These four discourses were sometimes complementary and often contradictory. In the following sections I will describe each of the six discourses and illustrate how they interacted to produce a network of knowledge about health equity as a concept, and how FLS related to this concept in frontline public health practice. I will also outline the similarities and differences between Phase 1 and 2 to illustrate how discourses changed or did not change over time.

The position of health equity in FLS’s practice

The two micro individual discourses of health equity as a high priority for FLS and health equity as implicit were nearly universal among FLS.

Health equity is a high priority

The discourse of health equity as a high priority described how health equity was situated within FLS's public health practice. Health equity was clearly a foundational value for essentially all the FLS who participated in the study; no FLS said that health equity was not a priority in their practice. This discourse was similarly strong in both phases, with little discernable difference over time, suggesting that health equity was as an enduring value over the time period of this study. Some FLS articulated a personal or team commitment to health equity with comments like:

> Interviewer: So, to what extent would you say that health equity would be a priority for you guys?
>
> Participant 154: Well it's a high priority.
>
> Participant 155: I would say it's a high priority for our entire office and everyone that works here I think. (INTV 112, Phase 1)

Some FLS framed health equity as a conceptual cornerstone of certain programs, such as outreach or perinatal programs, while others noted that health equity underpinned all the programs they offered. In the words of one FLS:

> We have these conversations [about health equity] all the time. How do we find the resources people need to get to their appointment, or how to help this family have food to get through the week? (Participant 139, FG 119-2, Phase 2)

FLS in both phases reported spending a significant proportion of their time on health equity.

A few FLS depicted health equity as a core value of public health practice and public health nursing. When asked what supported them to integrate health equity in their practice, one FLS answered, “It’s also public health nursing, public health value as far as our- our ethics, and our beliefs around providing service” (Participant 101, FG 101, Phase 1). These FLS associated health equity with the unique role of public health within the health system. One commented:

> I think that as public health nurses we are really good at trying to, as they say, meet people where they’re at, and really trying to like- like you said, we do a lot of outreach, which then makes health care more equitable because we are accessing people that would otherwise not access care. So obviously, then, it’s more onerous than on the health care professionals’ list of responsibilities or whatever. (Participant 137, FG 109, Phase 1)

A few FLS talked about these elements of public health practice as part of the unique “big picture thinking” (Participant 1003, FG 120-2, Phase 2) of public health, in contrast to the short-term, downstream and costly emphasis of acute care.

Health equity is implicit

ELPH’s program of research used health equity as the central concept of the study, and in the focus groups, interviewers asked participants about their understandings of health equity and how they promoted it in their work. Most FLS in both Phase 1 and 2 said that although health equity was a high priority, they did not regularly use the term ‘health equity’. Instead, FLS used a range of other terms to gesture towards health equity, and they used the same range of terms in both phases. For example, when asked, ‘do you talk about health equity in your work?’, one group answered:

> Participant unknown: Do we use the term equity? No, it’s just ‘not fair’.
>
> Participant 127: I talk about poverty, and housing problems-
>
> Participant unknown: Barriers.

> Participant 127: And barriers and that.
>
> Participant unknown: But we never use the term ‘health equity’, no. (FG 108, Phase 1)

Other FLS used terms that focused on service delivery, like accessibility, cultural competency or targeted and universal services. Still others used words with ethical underpinnings like social justice, inequity or unfairness. Other FLS said they talked about health equity “a bit more in practical terms” (Participant 1007, FG 119-2, Phase 2), discussing specific barriers to service or social determinants of health that clients were struggling with and how they might address those issues.

However, FLS made it clear that the concept of health equity was firmly embedded in their work, as these participants described:

> Participant 185: I’d say it’s integrated into what we do, as Participant 187 has said, in our practice. But I don’t say we use the term. I don’t hear the term used a lot, to be honest.
>
> [Others agree]
>
> Participant 187: But I think we talk about it a lot. (FG 114-2, Phase 2)

Some FLS did not use the term because they didn’t know what it meant, while others intentionally chose not to use it. For example, when asked directly to define the term health equity, a few FLS in each phase struggled because they hadn’t heard it before. What usually ensued was a conversation among participants to arrive at a definition. The following is typical of the few instances where FLS said the term health equity was unfamiliar:

> Interviewer: What does health equity mean to you? How do you understand it? Do you talk about it? Or do you use it?
>
> Participant 1017: I have to say, I haven’t even heard of that term before this study. Have you guys?

> Participant 1019: We have, probably in school.
>
> [Laughter, indiscernible chatter among participants]
>
> Unknown participant: Equity, equity, equity, equity.
>
> Participant 1020: Is that like equality? Like offering services to everyone? Sort of the broad- is it around that?
>
> Interviewer: Well, I'll let you-
>
> Participant 1019: She's asking us.
>
> [Participants laugh]
>
> Participant 1020: Ohh yeah. Wow.
>
> Participant 1017: So what did you guys learn in school? (FG 122-2, Phase 2)

A lack of familiarity with the term health equity was rare in both phases.

Some FLS said that they intentionally resisted using 'health equity' because it sounded "academic" or "like a document" (FG 109, Phase 1). Others did not use it because they felt it made assumptions about clients and labeled them instead of addressing individual circumstances:

> We don't say the word 'health equity' but we really, I think, again, just try to sort of look at our families- not- it's not a one-way relationship; we're learning from our families and about their experiences, so where some of those barriers can be. But, not, again, just not making those assumptions about how that will look. (Participant 149, FG 110, Phase 1)

I will return to this critique of health equity later in this chapter.

Despite not using the term 'health equity' in their daily work, when asked, most participants had a clear sense of what the concept of health equity meant to them, freely sharing their perspectives on it, either by directly offering definitions of the term or by pointing to actions they took. This suggested that, regardless of FLS's varying reasons for not explicitly using the term, they still articulated health equity as an implicit priority in their public health practice.

The meanings of health equity among FLS

Despite the near-consensus among FLS on health equity being a high priority and an implicit part of their practice, there was considerable variation in how FLS articulated the meaning of health equity, conceptually and in practice. Indeed, a few FLS made the observation that health equity, as a "huge umbrella statement" (Participant 158, FG 106, Phase 1), might be able to hold many meanings simultaneously. One public health nurse (PHN) noted:

> I remember being in nursing school, and we had all this lingo about feminism, and empowerment, and- like, what different theories of nursing, and what did this mean, and how did it interpret to us, and- like, you know, and to me health equity's so big that in itself, like there's- it could be almost like a framework of something.… I mean it's going to mean different things to everybody. (Participant 107, FG 101, Phase 1)

In the spirit of this quote, in the rest of this section I outline the four discourses that articulate FLS's understandings of health equity: health equity is about access to services, health equity is about vulnerable populations, health equity is about individual needs, and health equity is structural. Each discourse makes certain claims about what produces health inequities and advances a certain perspective about what should be done to promote health equity. These four discourses operated at the micro individual level of the practitioner – their ideas, beliefs and attitudes.

Health equity is about access to services

The dominant health equity discourse at work at the micro individual level among FLS was that health equity was about access to services. This discourse was similarly widespread in

Phase 1 and 2, with FLS in both phases drawing on ideas of service availability and barriers to access. According to this discourse, health equity primarily involved ensuring that services were available when clients needed them. In the words of one, “With health equity, I, I feel that anyone that comes for service, either at [a co-located primary health service] or here, gets service” (Participant 144, FG 110, Phase 1). Another noted, “Health equity is the ability to access the type of health care that you want in a place that you want it, that you are comfortable” (Participant 1005, FG 119-2, Phase 2). I observe that these comments drew on ideas of accessibility, availability and appropriateness of health care common in early articulations of health equity (Whitehead, 1991). The discourse of health equity as access to services relied on the premise that inequities existed between people in terms of their health needs and/or their ability to access services and that appropriate health equity interventions should aim to reduce inequities in client access to services, but the discourse did not necessarily extend to reducing inequities in health outcomes.

Within this discourse, barriers to services were a key concern and area for action. As one FLS put it, “For me, I look at health equity as not just the- the availability of the service, but the- ability of the individual to access the service and what are the barriers to the access of that service?” (Participant 159, FG 106, Phase 1). FLS understood barriers as interactions between how services were designed (e.g., services only being provided in some towns) and people’s life circumstances (e.g., lack of access to a vehicle because of inadequate income). Reducing barriers to access was one of the actions FLS most commonly described taking in their efforts to promote health equity through their practice.

However, as I will discuss next, within the discourse of health equity as access to services there was a marked difference between two sub-discourses about what caused inequities of access and how they should be reduced: equality and equity. Equality and equity were in tension with each other, with FLS advocating for one or the other approach. However, some FLS saw the two sub-discourses as complementary and able to work together to promote health equity as access to services. In the following sections I describe the sub-discourses of equality of service access, equity of service access, and equality and equity together.

Equality of service access. When asked what health equity meant to them or how they promoted it in their work, many FLS gave examples that drew on the idea of equal access to services regardless of personal characteristics or social circumstances. When FLS defined health equity in this way, they typically described it as "equal types of service for all clients, no matter what your issues or your background or your ethnicity is, you know. Equal, you know, access to health care for everyone, everywhere, anytime" (Participant 199, FG 118-2, Phase 2). Equality of service access in this case assumed that providing the same services to all clients was an effective way of decreasing inequities in access.

In a slightly different perspective, equality of access was associated with that idea that all people were entitled to a base level of services. One FLS argued:

> [Health equity] doesn't always mean, as I kind of alluded before, that the same service is offered to everybody. But everybody has that same opportunity … everybody would still have access to that basic, bottom line stuff of getting that good support. (Participant 1031, FG 125-2, Phase 2)

This definition of equality was more nuanced in that it assumed that different people might need different services, but still emphasized the importance of an equal minimum level of services.

Equality might also involve assessing where there were inequities in service availability across a health system and remedying those inequities. One nurse in training commented:

> Being a student, we've been everywhere working, not just with nurses, but other health care providers, and you do notice the gaps more frequently, like hopping around like that. And seeing like, well, they only offer up to here [measures height with hand], and you only offer up to here [measures lower height], but now there's- and so I think the biggest thing about getting that equal health care to everybody is those gaps. (Participant 158, FG 106, Phase 1)

This quote referred to equality of levels of available services instead of levels of individual access. The articulation of health equity as equality of access was similarly present in Phase 1 and 2, with no discernible differences between the two phases in how equality was articulated.

Equity of service access. In contrast, other FLS articulated health equity as equity of access to services. This FLS made the distinction between equality and equity of access:

> [Equity is] different from equality because with equity, everyone's situation is different. So you're looking at that individual or that family, and trying to develop programs that meet them where they're at. Whereas equality would be for everyone. So equity is more, I guess, specific in terms of making sure access to care is equitable to everyone's situation. (Participant 1019, FG 122-2, Phase 2)

This sub-discourse also recognized inequities in access but attempted to address them by providing different services to people with different health needs or different barriers to access.

Equity of access was described in two main ways, as more services for people with higher needs and as more services for people who faced more barriers. The most common articulation of equity of service access involved providing "more services to people who have higher needs" (Participant 1031, FG 125-2, Phase 2). 'More services' might include more intensive time, access to programs or material resources given to clients with higher needs, particular life circumstances or certain identities. One FLS described how the program they worked with:

> [used] the equity lens to try and provide more services to those with greater need. So we are screening for health indicators, like income, age, etcetera, to try and identify those that might have a greater risk of health disparities and provide services. (Participant 124, FG 108, Phase 1)

Another FLS described what ‘more services’ might look like in the case of clients with certain mental health and substance use experiences:

> If there is concern about substance use, you’ve seen them [on the discharge planning form] where they tick it or- history of depression- they tick that [on the form] and so- then I would zero in a little more and ask a few more questions and it might lead to a home visit, it might lead to resourcing her to more things, so then that equity piece, or providing her with more. (Participant 157, FG 106, Phase 1)

Like equality, equity involved mitigating barriers to service access, but by specifically targeting more services to people who experienced more barriers. This might involve providing additional resources to certain clients, such as the widespread practice of offering young clients birth control at low or no cost. FLS also used strategies to address barriers related to the social determinants of health (SDOH), like putting “things in place in our groups to try and make them as accessible as possible. Such as, like transportation and child minding and nutrition coupons to try and just make it as available and accessible to everyone” (Participant 146, FG 113-2, Phase 2). As this quote illustrates, barriers were understood to create inequities between clients’ ability to access services and the goal of equity was to reduce the barriers faced by some clients.

A common strategy that drew on ideas of equity in order to mitigate barriers faced by some clients was outreach – providing services outside of health units. One PHN described how their team offered outreach to clients who did not use services:

> The way that we try to address that is by developing relationships with them outside of the usual places where these services are available, going to their homes, meeting them in places where they feel comfortable and running clinics in places that they feel comfortable as well.… So it really increases people's ability to approach us and access the services that we have through outreach. (Participant 181, FG 113-2, Phase 2)

Most public health units that participated in the study offered some kind of outreach services, whether formally through a specific program such as an outreach team or youth clinics in schools or informally with individual clients who were assessed to have barriers to access.

Equity not only meant more services for higher needs but less services for lower needs. This FLS explained the idea behind the equity-informed distribution of time between perinatal clients: "Those that are doing really well and healthy families, we should spend less with them and more time with the at-risk … that's the ultimate goal" (Participant 157, FG 106, Phase 1). These kinds of comments were only articulated by a few FLS but I will note that they pointed more explicitly towards the idea of equity as a redistributive principle, which is common in many ethical and conceptual formulations of health equity (Anand et al., 2004; Heller et al., 2024; Pan-American Health Organization, 2001, 2019; Pauly et al., 2009).

Moving this broader redistributive understanding to an organizational level, one participant defined health equity as how resources were distributed across the organization to address inequities between communities:

> 54% of our 18-year-olds graduate from high school. The median income was below the BC average. The teen mom rates were higher. So a lot of those things play into the health

> of the community. We have higher smoking numbers, higher blood pressure…. So those are some of the things I'm looking at is, how is the health of our actual community in comparison to the rest of the province? And then, does the staffing meet up with it? (Participant 1042, FG 129-2, Phase 2)

This perspective was a rare example of both an explicit reference to redistributive equity and an articulation of equity that involved the distribution of resources across the health system instead of between clients.

The sub-discourse of equity of service access as an idea and practice that distributed FLS time and resources according to client needs and barriers was similar between phases, both in terms of how FLS articulated it and the frequency with which it was visible in their talk.

More than equality, talk that invoked the sub-discourse of equity was often linked to SDOH, with FLS considering how various social factors impacted clients' health needs and barriers to services and how public health interventions might address these factors. The three assumptions that linked SDOH and equity were that SDOH had a direct impact on health needs and barriers, that inequities in SDOH existed within the population, and that those with poorer SDOH should receive more services.

Equity and SDOH together manifested in FLS's practice in a number of ways. FLS often focused on SDOH when assessing clients' needs and barriers, as these FLS indicated:

> I think you can't talk about equity without looking at social determinants of health, which is basically how we determine where people fall [in our assessment] anyway. [Others agree] But it's a scale, right? Like, someone may have financial issues, but mental health wise may be fine whereas someone else might have severe mental health problems, but then financially… [trails off] (Participant 1019, FG 122-2, Phase 2)

Once clients were identified to have poor SDOH, interventions usually involved increasing the amount or intensity of public health services offered to them. FLS also worked to decrease SDOH-related barriers to service by offering clients supports like child minding to ensure that they could access services. However, in other cases, FLS aimed to improve clients' SDOH directly by offering them material resources such as free food or clothing, or by supporting clients to ameliorate their SDOH by accessing non-public health services, as described here:

> Participant 187: I think the work, especially that our [paraprofessionals] do…
>
> Participant unknown: Amazing.
>
> Participant 187: …they do a lot of that sort of thing. So like, access to housing.
>
> Participant 187: Like, filling out forms so that they can get childcare tax benefit, whatever it's called, like stuff like that. Because there's literacy barriers or what have you.
>
> Participant 184: So BC Housing rental assistance program, taking them to the food bank, taking them grocery shopping. (FG 114-2, Phase 2)

The work of improving clients' SDOH directly happened most often when paraprofessionals were part of the public health team.

Phase 1 participants very rarely included SDOH in their definitions of health equity, whereas this was more common in Phase 2. Phase 2 participants also talked more often about considering and attending to SDOH in their practice.

Equality and equity together. Although I have presented equality and equity as two distinct sub-discourses articulating the meaning of health equity, many FLS saw them as able to unproblematically coexist within the overall concept of health equity. As this PHN argued, "Health equity isn't just focusing on at-risk clients, and ignoring people who we consider might be less at-risk, but it's about kind of opening up service and making it a safe place for everybody to come" (Participant 146, FG 110, Phase 1).

A common framework for the complementarity of equality and equity was one central to public health practice: universal and targeted approaches to service provision. FLS in every focus group used the concepts of universal and targeted approaches to point to their understandings of health equity, as indicated in the following quote:

> Interviewer: If we want to get at kind of the initiatives that are promoting health equity, and over- kind of helping people to overcome obstacles, and so on, what kind of language? How would you talk about that?
>
> Participant 101: I think some of the language you already used is targeted versus universal services. We use those quite a lot, anyway. (FG 101, Phase 1)

Like FLS's articulations of equality of access to services, universal approaches involved providing a base set of services that were available and accessible to the entire population. Like their articulations of equity of access to services, targeted approaches involved giving specialized attention to certain clients who had more needs or barriers to care.

Almost every focus group in both phases described offering a mix of services guided by sub-discourses of equality and equity in their unit and valuing the presence of both:

> Participant 1012: Public health services are free for all populations.
>
> Participant 1010: But we do provide, like, extra services.
>
> Participant 1016: We have enhanced services for what would be considered vulnerable populations, for sure [others agree]. (FG 121-2, Phase 2)

Many FLS strongly believed that there was an appropriate (and inappropriate) balance between universal and targeted approaches. The discussion below begins to illustrate that idea:

> Participant 190: If we think of health equity as access to services, then postpartum with maternal newborn care, the fact that we're calling or making some sort of contact attempt for every woman in our community who has delivered a baby, is connecting or, you know, making sure everyone is receiving equitable care.
>
> Participant 189: And with the [perinatal program], I think they're trying to get equitable care but I am concerned that they're missing out on some of the universal care.
>
> Participant 190: So services are more focused towards more high-risk women and families, as opposed to generalized service. (FG 114-2, Phase 2)

This group described both universal/equality-informed ("every woman in our community") and targeted/equity-informed ("high-risk women and families") approaches and commented on what they thought was an inappropriate distribution of services between the two.

These examples suggest that many FLS made space for some multiplicity in their micro level articulations of health equity instead of seeing it as a unitary concept, especially within the framework of universal and targeted approaches. Not all FLS agreed that equality and equity could coexist unproblematically, though; some believed that one or the other should dominate in a particular program or in public health practice overall. I return to the issue of the appropriate balance between equality/equity and universal/targeted approaches in the next chapter, where I discuss how the organizational context impacted FLS's ideas about this balance.

There were some differences between phases in how FLS articulated equality and equity together. In Phase 1, FLS invoked both equality and equity but less often highlighted tensions and contradictions between them, either conceptually or in the way each played out in service provision. In this phase, equality and equity tended to coexist side by side, as in this example above: "Health equity isn't just focusing on at-risk clients … it's about kind of opening up service and making it a safe place for everybody" (Participant 146, FG 110, Phase 1). In Phase 2, FLS were more likely to discuss the differences between equality and equity or argue that one or the other should dominate; as in the quote above about postpartum maternal care, where FLS described the tensions between equity and equality in service delivery: "I think they're trying to get equitable care but I am concerned that they're missing out on some of the universal care" (Participant 189, FG 114-2, Phase 2).

Health equity is about vulnerable populations

As many of the examples in the previous sections have demonstrated, FLS often discussed promoting equity of access at the individual level, on a client-by-client basis. FLS might use their discretion to spend more time or more resources on an individual or family they judged to have higher needs. However, equity of access was also closely tied to the idea that certain groups of people had, on average, higher needs. This idea was the foundational premise of the micro individual discourse of health equity being about vulnerable populations, in which certain groups of people were described as 'vulnerable' or 'high-risk' based on a particular set of criteria. Health equity, according to this discourse, therefore involved not just providing more services for higher needs but "enhanced services for what would be considered vulnerable populations" (Participant 1016, FG 121-2, Phase 2), shifting the frame of assessment and intervention from an individual to a population approach.

'Vulnerable' and 'high-risk' were the two most common terms FLS in both Phase 1 and 2 used to describe clients that they considered to be in populations with higher needs. This is an example of how high risk was defined:

> Interviewer: What are people meaning when they say 'high risk'?
>
> Participant 189: Substance abuse.

> Participant 186: Substance abuse.
>
> Participant 189: Mental health.
>
> Participant 186: Mental health, low income.
>
> Participant 189: Age.
>
> Participant 183: Poverty, or…
>
> Participant 183: Guess that goes with low income.
>
> Multiple participants: Social determinants.
>
> Participant 184: Well it comes to barriers, right? It comes to barriers. Social injustice.
>
> Participant 189: Moms that may have had a child or two before apprehended, for, problems. (FG 114-2, Phase 2)

Clients who were high risk or vulnerable might have particular life experiences such as poor mental health or having had a child apprehended, but more often FLS tied vulnerability to clients' SDOH such as income and age. SDOH related to other aspects of identity were also closely associated with the category of vulnerable. A number of FLS discussed how Indigenous identity was considered a criterion for vulnerability, noting that "if a woman identifies herself as being Aboriginal, she automatically qualifies for enhanced public health services" (Participant 1004, FG 119-2, Phase 2).

Based on the discourse of vulnerable populations, clients with certain life experiences or poor SDOH were understood to have on average more need for services and/or more barriers to accessing them. Being assessed as vulnerable meant that clients became eligible for additional services. For example, a FLS commented:

> We get these clients that are considered vulnerable. They're more ones that we're following really closely and then doing that health equity with them versus other people

> that maybe don’t score as a vulnerable person. They [people who don’t score as vulnerable] might get a letter in the mail, and then they say, ‘you can access our services as needed’. But we’re not really closely following them. (Participant 1018, FG 122-2, Phase 2)

Being assessed as ‘not-vulnerable’ resulted in clients receiving fewer services, suggesting that redistributive principles were also present in the discourse of vulnerable populations.

The ideas of vulnerable and high-risk were also used to determine which populations should be targeted for outreach. Describing an outreach strategy that focused on working with a particular population to deal with an infectious disease outbreak, one FLS described:

> We had the ability to go out and meet people and so that support was given. That was identified as a priority and those are super high-risk clients that we took a lot of time and did things outside of the box to make it work. (Participant 139, FG 119-2, Phase 2)

Outreach services that were informed by the discourse of vulnerable populations made the population approach of this discourse especially visible because outreach was delivered based on the principle of prioritizing certain populations as a whole for more services.

In the case of individuals and families, identifying clients as vulnerable or high risk might happen based on what FLS knew about clients, but it also happened through formal assessments for specific public health programs, as some of the quotes above demonstrate. As an example of this, one FLS described how the program they ran was intentionally targeted to clients with higher needs:

> Some of our services are targeted for those who may have experienced barriers or challenges based on any of the social determinants of health. So, some of our programs are specifically meant to involve that screening [assessment] so that we can identify who

> might need more service, and then we try and offer more based on that screening. (FG 108, Phase 1)

In fact, FLS's understandings of vulnerable were often shaped by formal program assessment criteria:

> Participant 1017: Somehow, vulnerable to me means, I don't know…
>
> Participant 1018: [names a program stream]
>
> Participant 1017: Yeah. [people laugh]
>
> Interviewer: What's [program stream]?
>
> Participant 1018: Oh, [program stream]. It's just part of our [perinatal program]. They have different [program streams] depending on…
>
> Participant 1020: Are you guys familiar with that? It's provincial.
>
> Interviewer: [Perinatal program]? Yes.
>
> Participant 1020: Yeah. So in a way, that's categorizing people right away, right? So, given a [program stream].
>
> Interviewer: It's a targeted. [others agree]
>
> Participant 1020: Yeah, it is targeting whether you look at it as health equity or vunerab- ah, I don't know. Because they use the word vulnerable, right, in that [program stream]?
>
> Participant 1018: That's why we say vulnerable. (FG 114-2, Phase 2)

As this quote illustrates, within the discourse of health equity being about vulnerable populations, criteria that allowed FLS to 'score' clients as a vulnerable person were not only used as information to decide whether these clients should receive additional services, but were mobilized to conceptually place clients into discrete categories of people who were assumed to share certain characteristics. The discourse of health equity being about vulnerable populations fundamentally assumed that inequities of need and barriers existed between groups, and vulnerable people or populations experienced more needs and more barriers to services, and therefore should be eligible for enhanced services. The tendency to define vulnerable by referring to specific program assessment criteria was only present in Phase 2.

Together, these ideas and practices produced the discourse of health equity being about vulnerable populations, which governed how FLS identified a vulnerable client and decided on the appropriate services to provide to them. The discourse of vulnerable populations provides a striking example of how health equity ideas and organizational practices are closely tied together.

Health equity is about individual needs

The sub-discourse of equity of service access and the discourse of health equity being about vulnerable populations were both based on the idea that inequities resulted from systemic patterns in the health and social conditions of clients and that organizing access to services along the lines of these patterns was an ideal way to decrease inequities. However, I also found a strong chord of resistance to systemic articulations of health equity among FLS, particularly to the discourse of health equity being about vulnerable populations. I have called this resistance the discourse of health equity being about individual needs.

A number of FLS felt that the vulnerability discourse was inherently unfair because it categorized people using labels (e.g., vulnerable or not-vulnerable) and made essentialist assumptions about people who fell under each label. Some contended that assessing people as vulnerable “feels unequal, because you’re running around labelling people” (Participant 1016, FG 121-2, Phase 2). This perceived unfairness was, in part, because the categories inherent to systemic discourses of health equity foregrounded client deficits: “It’s almost like to say ‘health equity' does bring to mind almost like a little bit of a deficit kind of language [a few people agree] and we're trying to be really focused on strength based language" (Participant 149, FG 110, Phase 1).

As I discussed earlier, although definitions of vulnerable were sometimes based on clients' experiences, they were more often based on social categories. It was mostly the restriction of services to certain social categories that FLS found essentialist. For example, some FLS felt that identifying clients as vulnerable or high risk solely because they were Indigenous was "marginalizing" and "disgraceful" (Participant unknown, FG 123-2, Phase 2). One FLS illustrated this point in more detail:

> Well, one of the things that [lowers volume] and I always find this kind of interesting because it's, it maybe could be a trigger for a lot of people is that if you have Aboriginal ancestry you automatically get enhanced services … it's called a risk factor to be Aboriginal. Like, it's not a strength.… In trying to address I guess a health equity issue, it [whispers] just becomes kind of racist. (Participant 1000, FG 120-2, Phase 2)

These FLS understood the categories and labels informed by systemic articulations of inequities to reproduce ideas and practices that generated inequities instead of challenging them. Almost all critiques of Indigenous identity as a 'risk factor' occurred in Phase 2.

Being assessed as vulnerable might entitle clients to additional services, but it also created 'boxes' that clients had to 'fit in' or 'check off'. In the words of one FLS, "if you don't fit into my ticky boxes, you don't get seen" (Participant 1031, FG 125-2, Phase 2). Many FLS believed that the categories or 'boxes' used to assess eligibility for enhanced services often did not accurately identify clients who needed more support. This meant both that clients who needed more services were sometimes not eligible for them and that clients who were assessed as vulnerable did not always need those services. As the FLS quoted above argued, “just because you’re Aboriginal doesn’t mean that you have a whole bunch of vulnerabilities. But you could be non-Aboriginal and have vulnerabilities that are not identified” (Participant 1004, FG 119-2, Phase 2). This perspective, particularly the idea that “people that don’t meet the criteria could slip through the cracks” (Participant unknown, FG 108, Phase 1) was common in both phases.

FLS often illustrated their frustration with the mismatch between assessed and real need by giving examples of people who would not have appeared or been assessed as vulnerable but who still needed public health services. The following is a typical example:

> There’s always this assumption, sometimes, if you have money, or you’re middle-upper class, you got it all together. And we’ve seen it, they don’t. And same with [perinatal program], it kind of leads you in this direction that it’s really for those- I don’t want to use the word have-nots, but it’s like saying the haves all got it together, and I’m sorry, they still have mental health issues, they still have substance issues, they still have physical abuse, they still have all the problems. Yeah, okay, there’s a bit more money in their bank account, but it doesn’t mean that they don’t have problems. (Participant 155, INTV 112, Phase 1)

These comments highlighted the ways that some FLS believed that structured and formalized ways of categorizing clients and providing services *produced* barriers to services. These FLS thus characterized equity and vulnerability as discourses that inappropriately translated differences of social circumstance into assumptions about need.

Instead, the discourse of health equity being about individual needs posited that it was more appropriate to organize services based on individual characteristics and conditions instead of on systemic patterns. One FLS explained this distinction: “Health equity would mean to me looking at sort of what families need and addressing that. They may not necessarily be vulnerable. They just may be different than other families. Just because you're different doesn't mean you're vulnerable" (Participant 1017, FG 122-2, Phase 2). The discourse of health equity as individual needs pushed back against the ways in which, according to FLS, systemic articulations of health equity erased the individuality of clients, which undermined relational and client centered care. Reflecting on the strategies her team used to ensure that clients who did not meet criteria for enhanced services still received care, one FLS said:

> I think because that's our lens, and I think we do a really good job at trying to be client centered, and family centered, so that is why have difficulty with the language, of like high risk or vulnerable, or 'requires this' or 'requires that'. (Participant 1004, FG 119-2, Phase 2)

This team attempted to prioritize what clients identified as their needs instead of strictly working within program-defined categories of need and eligibility.

Even when FLS who espoused the discourse of individual needs recognized that certain populations might have unique needs, they preferred to emphasize difference over inequity. For example, when asked to define health equity, one FLS answered:

> I think recognizing where people are at, everyone's at a different place and stage and to make sure that they have equal service within healthcare and that their needs are being recognized or, through looking at different cultural norms. So like some of our HIV clients or transgendered, like they're just in a different subculture. In order to provide them with equitable healthcare, I think you have to recognize that they may have their own specific needs. (Participant 1016, FG 121-2, Phase 2)

In this way, the discourse of individual needs did not foreground inequities between populations, using instead the language of “different subculture” and “their own specific needs”.

In a few rare cases, an individual needs approach coexisted with considerations of systemic inequity and a populations approach:

> Although we’ll look at some of the things like, yeah, just being culturally responsive care or a disability lens, whatever, we’re conscious to, I think, not- ‘We need to do this program because of health equity’ like it’s sort of- yeah, what’s relevant now for who we’re looking at now? (Participant 149, FG 110, Phase 1)

This suggested that a few FLS saw systemic and individual articulations as able to coexist. The same FLS clarified:

> We need to be accessible to everybody, but without assumptions, because I really do think we’re often caught by surprise. Folks who don’t fit profiles have some very significant need. So it’s a bit of a dance around that, so looking at those populations but also really being careful to listen to stories and respond to individual circumstances. (Participant 149, FG 110, Phase 1)

This ‘dance’ allowed FLS to balance the tensions between individual and systemic articulations of health equity.

The discourse of individual needs was present in both Phase 1 and 2. In Phase 1, resistance to systemic approaches tended to be unequivocal, whereas in Phase 2 it was more nuanced, with more FLS valuing both individual and systemic articulations of health equity.

Health equity is structural

I have shown how the discourse of health equity as equity of access to services and the discourse of health equity being about vulnerable populations sometimes used SDOH as evaluative criteria to assess whether a client or group had more needs or more barriers to service.

These two discourses posited that inequities existed in SDOH, but in both, the appropriate course of action to reduce inequities was to provide more services to clients or groups with more needs or barriers. Although these discourses considered the impacts of social factors on clients, they still located ideal actions to promote health equity at the level of individuals, not at the level of larger systems that inequitably distributed the determinants of health among people in society. The discourse of individual needs explicitly pushed back against considering the impacts of larger systems, preferring to focus on the individual or the family.

The last micro individual discourse I describe in this chapter, the discourse of health equity as structural, also invoked SDOH in relation to inequities but shifted the target of appropriate action beyond service provision to the more structural levels of community development and public policy. This discourse was much less prevalent in FLS's talk about health equity than the other discourses. The following quote is an example of how some FLS linked health equity to public policy issues via SDOH:

> I think what we've been talking about is health care or health services inequity, but there's also just health inequity, right? Like poorer people have poorer health outcomes and that really speaks to the social determinants of health which [laughs] it's all just complex, so yeah, how to have a good life: don't be born to poor parents, don't be born to uneducated parents, and those kinds of things [other participants make noises of agreement]. I mean I think until we can look at more poverty reduction, food insecurity, and shelter and some of those really higher up issues, it's going to be, inequity is going to continue obviously. (Participant unknown, FG 123-2, Phase 2)

The discourse of health equity as structural shifted the focus away from health needs and access to services and towards health outcomes, which was rare in the discourse of health equity as access to services and the discourse of health equity being about vulnerable populations.

The discourse of health equity as structural posited that inequities in SDOH required solutions that were more structural in nature than service provision, as the following quote demonstrates:

> Participant 184: I think health equity needs to go beyond just everybody is entitled to the same services.
>
> ….
>
> Participant 187: Like affordable housing here, is ridiculous.
>
> [overlapping as others name social determinants of health]
>
> Participant 184: How about food? Having food banks, living in a society that has food banks to me doesn't look at health equity either because we don't have proper nutrition.
>
> Participant 188: Transportation. We don't have the buses.
>
> Participant 183: Childcare. Not only having childcare you can afford, but childcare you can trust that you can afford. A job that supports you finding childcare that you can trust and afford. You know, because that one client you were talking about, her access to mental health is compromised because of her ability to have proper childcare.
>
> (FG 114-2, Phase 2)

Similar to ideas about equality involving entitlement to a base level of services, some FLS highlighted the importance of ensuring that all people had a base level of SDOH, saying things like, "I thought, 'oh, health equity', so I put like, 'healthy community, healthy living for all' so everybody has a right for healthy foods and things like that" (Participant 154, FG 108, Phase 1).

A few FLS talked about attempting to address inequities through their practice by participating in community development initiatives. One talked about how the youth nurses in their unit have:

> recently identified a pattern of sexual assaults that is happening in [our city], and trying to figure out how to connect with community partners and do some work around education, and to prevent what they see as a shift that's been happening.… And rather than working with one young person at a time coming through the door telling this horrific story, how do we start to have different kinds of conversations or community supports in place that gender violence basically shifts? (Participant 139, FG 119-2, Phase 2)

Community development work intentionally shifted the locus of action from an individual service provision level to a more systemic community level.

Other FLS engaged in public policy advocacy to promote health equity. One PHN described how they:

> do a lot of the larger social determinants of health, things around housing, around literacy, working with political- in terms of helping communities to be aware of what the social determinants are and what differences we can make in trying to make- that much less rewarding work of policy and funding, at the larger planning- working with planners, working with trying to do that bigger kind of step back piece. (Participant 129, FG 108, Phase 1)

Within the discourse of health equity as structural, rarely did FLS direct their talk further upstream than inequities in SDOH and how they were linked to community level factors and public policy decisions. Very few FLS talked about the role of social, cultural and economic forces in producing the circumstances they witnessed in their clients' lives. For example, one blamed "large economics" (Participant 1039, FG 129-2, Phase 2) for food security issues in remote communities and another named colonization as a significant factor impacting clients. However, FLS never described acting on these upstream causes of causes, nor did they call for this kind of action from their own organization or other public institutions. This is understandable given the kinds of work FLS described doing, which may have limited their focus and field of influence to mostly service provision. Broader challenges related to implementing upstream interventions in public health that I described in Chapter 2 may have also played a role in FLS's downstream focus.

As infrequent as the discourse of health equity as structural was in FLS's talk, it was slightly more common in Phase 2 than in Phase 1, with more FLS in Phase 2 talking about the need for or discussing their work at community and policy levels. In Phase 1, no FLS talked about the larger systemic causes of causes that produced the circumstances their clients were facing.

Chapter summary

The FLS who participated in this study were all women and worked in a range of public health areas, including mental health promotion; the prevention of harms of substance use; maternal, infant and child services; and community-based public health service provision. There was near-consensus that health equity was a high priority in their practice, although FLS said that it was implicitly embedded in their work instead of using the term explicitly to describe what they did. The predominant micro level individual discourses in circulation among FLS articulated the concept of health equity as access to services, health equity as being about vulnerable populations, and health equity as meeting individual needs. A different and much less dominant discourse was that health equity was a structural phenomenon that should be addressed in structural ways.

Chapter Five: Relational Factors Impacting Health Equity Work

In the last chapter, Chapter 4, I demonstrated that FLS articulated their understandings of the concept of health equity and appropriate action to promote health equity through a range of discourses. I established that even though FLS did not frequently use the words ‘health equity’ to describe what they did, they placed a high priority on it, seeing it as a value of public health and as essential to their practice. I then mapped out four discourses articulating the meaning of health equity and showed that many FLS saw some of these discourses as able to coexist unproblematically. However, other discourses were positioned in confrontation or resistance to each other, such as the discourses of vulnerable populations and individual needs.

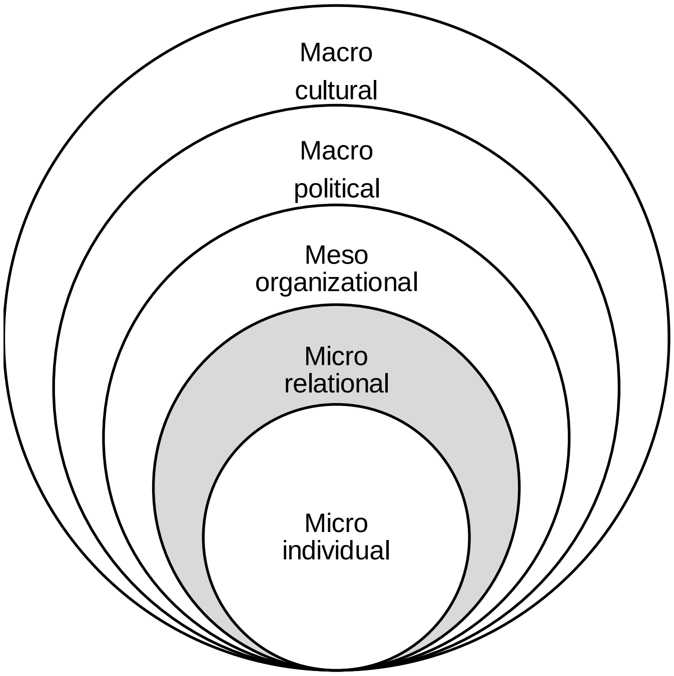
Chapter 4 focused on discourses relating to the micro individual level – FLS’s own ideas, beliefs and attitudes about health equity. In this chapter, I turn my attention to discourses concerning the micro relational level (the shaded element in Figure 4) in order to start to answer the second part of my research question: *How do frontline public health staff articulate how relational factors impact their work on health equity and how does this change over the period of study?* There were two key discourses at work at the micro relational level: the discourse of trusting relationships with clients and communities and the discourse of supportive organizational relationships.

Trusting relationships with clients and communities

Relationships with clients and communities were the micro relational factor that FLS talked about most. The dominant discourse I identified at this level was the discourse of trusting relationships. Foundationally, FLS understood relationships to be essential to good public health practice, noting, “we all know in public health, it’s a value, right, it’s the core value, it takes time to build relationships” (Participant 157, FG 106, Phase 1). FLS believed that relationships with

Figure 4:

This chapter focuses on discourses that refer to the micro relational level of FLS's context



clients and communities underpinned many of the discourses articulating the concept of health equity that I discussed in the last chapter – relationships promoted and enabled health equity as access to services, health equity for vulnerable populations and health equity as structural.

Relationships support health equity as access to services

FLS understood trusting relationships to directly support their articulations of health equity as access to services. Relationships allowed clients to trust FLS enough to receive services. One FLS said that for her clients, it was difficult:

> for them to trust and allow the system to do what it should do.… And then working in home nursing care I come across again, like poverty, being able, the interculturalness, the awareness of different cultures, to be able to accept services. And then also, again trust, huge amount. If you build a relationship with somebody, that you can come into their

> lives and provide the type of care they may require. (Participant 107, FG 101, Phase 1)

A trusting one-on-one relationship with a provider was a precondition for clients to "let go, to some extent, to access the services" (Participant 107, FG 101, Phase 1).

Relationships also facilitated service provision by allowing clients to disclose issues they were facing. Many FLS felt that:

> if you create a relationship with your client, it removes a lot of barriers, because then they start telling you what their actual inequities are.… And that, I think, brings down a lot of barriers to people to care. So they can start admitting, you know, if some mental health problems, things that they don't tell people, you know? Substance use, things that they may not admit to someone that they don't know. So the trusting relationship that we can make in this office, I think really helps with that inequity. (Participant 183, FG 114-2, Phase 2)

Relationships support health equity for vulnerable populations

Trusting relationships were particularly important when working with vulnerable populations who had reason to distrust service providers due to past experiences of discrimination in the health system for being Indigenous, poor or otherwise marginalized or with clients who faced barriers to navigating the complex array of health systems and services. This FLS described how taking a non-judgemental approach at a volunteer outreach program impacted client access to services:

> Through that, people have seen me and I've been able to develop my relationships outside my work environment, but they translate into a sense of trust. So they know I'm not going to be judgmental and I strive not to be because sometimes those things do come up that one has to, perhaps [pause] move forward on. And out of that, I've been able to

> do HIV testing with people that had addiction issues. Really hard to access veins, that sort of thing- afraid that they're going- if they go see their doctor, they get a lab requisition, they go over to the lab, and then people make a big scene. How they smell, how they look, those things. (Participant 159, FG 106, Phase 1)

FLS also emphasized the importance of relationships in population-based services such as school health and community outreach, as this FLS described:

> Thankfully we had been going to the soup kitchen so when the TB outbreak happened- I mean, it takes a long time for them to even come up and talk to you in the soup kitchen. They're like, 'Well what are you doing, and what do you have to offer?' So we- they sort of knew some of our faces and you know, because you know, now, having to go in there and do skin testing. (Participant 141, FG 109, Phase 1)

Without this trust, key public health goals, informed here by the idea of equity, would not have been realized.

Relationships support health equity as structural

Relationships also supported health equity as structural via community development. This FLS described how building relationships with a nearby Indigenous community enabled her to deliver public health programming:

> I've been very, very fortunate to have had the opportunity to really develop some really strong links with our Aboriginal communities. And so it took years to establish trust but now I, very often, are invited and pretty much, maybe twice a month at least, to [two communities], we do amazing, you know, programs.… It's been really fun to actually be invited- and trusted- to actually be able to cook with them so, it's been kind of a way to, to get to promote healthy eating, that way. (Participant 152, FG 110, Phase 1)

Other FLS echoed this, saying that their community development work, which they saw as a key element of health equity action, would have been impossible without strong and trusting relationships with partner groups and organizations.

The impact of not having trusting relationships

A number of FLS commented about the fragility of trust. One FLS described how a lack of time and consistency could easily damage the relationship:

> Participant 1033: I'm only here one day a week instead of where I used to be here three days a week. So that's just a hit or miss. They try to see me, I'm not here, that's it. Pffff, gone, I've lost them [non-verbal agreement from other participants]. And that's just- like all it takes is one or two little things and it's gone. And I don't even see them for immunizations. Like, the basics, they don't even see us.
>
> Interviewer: So it's pretty fragile.
>
> Participant 1033: It's very fragile. (FG 125-2, Phase 2)

This fragility meant that FLS not having the ability to build strong and trusting relationships had a significant impact on clients' access to services.

In both phases, the discourse of trusting relationships articulated the relationship between the practitioner and the client/community to be a key channel for ensuring that clients/communities could access the services they needed. Therefore, trusting relationships were a cornerstone of health equity and effective public health practice. FLS's talk about relationships was accompanied by an affective sense of care for clients and communities, and by anxiety and sadness when there was a risk of not being able to maintain those relationships.

The micro relational discourse of trusting relationships was closely associated with the micro individual discourses of equity of access to services and vulnerable populations, in that the potential positive impact of relationships and trust was emphasized for clients with more needs or barriers to services. However, it was also associated with the discourse of equality of access to services, in the sense that relationships were understood to be a basic precursor for providing public health services to all clients. The discourse of trusting relationships was also associated with the discourse of health equity as structural through the connections between relationships and community development. In sum, trusting relationships with clients and communities were essential to almost all the discourses at work among FLS about the meanings of health equity.

Supportive organizational relationships

The second micro relational discourse I identified was the discourse of supportive organizational relationships. While the first micro relational discourse of trusting relationships with clients and communities articulated that these relationships were a channel through which FLS could promote health equity, the second discourse of supportive organizational relationships posited that certain factors in FLS's work environment impacted their capacity to do health equity work. Within the discourse of supportive organizational relationships there were three elements: team members support each other, local managers are key to health equity action, and health system and community service providers enable health equity.

Team members support each other

For the most part, FLS described the collegial relationships within their teams and public health units as supporting them to promote health equity. Responding to a question about what supported them to apply health equity in their work, one FLS explained:

> Within this health unit, it's definitely the team. Like, we all support each other. You know, 'I've got this situation, kind of plain out of ideas, what do you think we can do?' And I think it's based on that philosophy: how can we support them [clients]? Like

> everybody is entitled to that access so what can we do to make that happen as a whole? (Participant 178, FG 113-2, Phase 2)

Thus, relationships with colleagues supported health equity in part through collaborative problem solving and sharing work.

For another team, positive relationships with colleagues directly supported a client-centered orientation to service delivery:

> We're quite a close knit workplace. Like I'm not saying we're best friends, everybody's not best friends with everybody here, but we work very well together. We're almost- I would say almost like a family in the fact that we support each other in whatever's going on in our lives.… And I think we do that here, for ourselves, and it's just a natural outreach to do that for our clients. And we're all very client centered, client focused. (Participant unknown, FG 108, Phase 1)

As I described earlier in this chapter, FLS believed that a client-centered approach that focused on building trusting relationships was key to health equity.

In response to a question about what supported them to do health equity work, this group said:

> Participant 183: Having [paraprofessionals], having the, you know, I think it was the…
>
> Participant 190: Multi-disciplinary teams.
>
> Participant 183: …yeah, multi-disciplinary teams.
>
> Participant 188: We have [name], and we've got [name].
>
> Participant 183: Family…
>
> Participant 186: Nutritionist, dietician, and a speech therapist.
>
> Participant 185: And a dental hygienist.

> Interviewer: And you’re all centrally, sort of connected to each other?
>
> Participant 189: Yes. They’re in-house.…
>
> Participant 189: And if you have a family that’s struggling, even if these guys are busy, sometimes you can get them just to pop down and say ‘hi!’ and connect with them and introduce themselves as the one running the group, so they’re more likely to actually come to group. (FG 114-2, Phase 2)

FLS saw the multidisciplinary, integrated and co-located nature of their teams as a factor that supported health equity work by attempting to lessen barriers to services.

Talk about colleagues was always accompanied by an affective sense of warmth, appreciation and pride. This was emphasized when FLS highlighted the unique characteristics of their own health units with regards to health equity. For example, FLS might say that their team prioritized relationship building with clients or offered home visits in a way that not all public health offices did. This team discussed how they consulted with clients and communities to shape their service offerings to ensure that the needs of certain clients or populations were being met:

> I think the other piece that we do really well, which I’ve heard, the themes come up from other people, is really consulting with our participants about what services are needed and having that be ongoing. So whether that’s youth, whether that’s families, whether that’s working in communities, but really listening and I think bringing that back to this table and then moving our services around. We’re incredibly flexible and we’re constantly looking at that and evaluating that.… I haven’t met a team that has done better than us, like, I think, yeah [laughter]. You’re talking to a very good team [laughter]. (Participant 149, FG 110, Phase 1)

When describing their teams, FLS always spoke in first person plural, using the words ‘we’ and ‘us’, suggesting that they identified with their teams and health units and saw the team as a key locus of service provision and of health equity oriented practice. The emphasis on local teams as a factor that supported health equity and a positive affective orientation toward colleagues were present in both phases.

Local managers are key to health equity action

FLS also said that managers and clinical coordinators impacted their ability to promote health equity. Some managers had their own commitments to health equity and mobilized resources to achieve this purpose, as was the case in this team:

> Within the health outreach program, it’s our supervisor who really promotes it [health equity]. She believes that everyone should have access to health care and so we try to be creative in ways that we can make that happen for them and she’s really supportive for us, to do that. (Participant 181, FG 113-2, Phase 2)

Local managers sometimes supported “creative solutions” (Participant 143, FG 110, Phase 1), which enabled FLS to promote equity of access to services by doing more for clients with more needs and barriers to services. For example:

> I can think of an example of a mom- a young mom I was working with, newly diagnosed with HIV, with her second pregnancy, First Nations. She had never been out of [our city] and she had to go to [a clinic] in [another city]. And, she had nothing. She’s on income assistance, she’d never traveled outside, and so, I said to [my manager], ‘How can I help her? Like I really want to support her’. And [my manager] said, ‘Well, do you want to take the van?… If you’re willing to stay at your sister’s, we’ll book her in [to accommodations] and take the van and you get two paid days.’ So thinking outside the

> box about that was really- I think that's [my manager's] forte, really, is thinking about how we might do it. (Participant 148, FG 110, Phase 1)

Managerial support specifically impacted FLS's ability to promote equity of access to services because creative solutions were more often needed when existing services did not meet the needs of clients who had more needs or barriers; this creativity required local manager support.

Many FLS described how autonomy permitted or encouraged by managers was a key factor supporting their ability to apply health equity in their practice. For example, managers might be supportive of FLS's attempts to create new programming based on community needs:

> I think management too is really supportive of us developing different programs.… 'Here's the idea that we want to pitch', and we usually get a lot of support with that which is really good because we as frontline workers get to see the need within the community and then we can develop some ideas which more often than not is supported. (Participant 178, FG, 113-2, Phase 2)

Another FLS explained how that autonomy might extend to the oversight of daily activities:

> In terms of management, I feel very well supported as well in terms of education and autonomy to like, they're not micromanaging my time. They trust that, you know, I can use my time to work where I feel my priorities are. (Participant 1023, FG 123-2, Phase 2)

This autonomy was sometimes active, when people at higher levels of the hierarchy encouraged FLS to use their professional judgement, and sometimes passive, when leaders did not interfere when FLS made decisions to prioritize certain activities.

However, some managers were not as supportive of health equity promoting activities such as outreach, which frustrated FLS:

> Participant 1037: I think we're really trying to find many different ways to make it low-

> barrier, and connect with people, and build those relationships. By doing outreach and going to the schools, by going to [a community service provider]….
>
> Participant 1036: We're certainly not told to do our work that way or even supported to do our work that way. In fact, often the opposite. 'Really, do you need to go to the high school every week?' Those kind of conversations.
>
> Participant 1044: No. Often we have to fight…
>
> Participant 1041: 'And if you're going to be there, don't complain about the other things you have to do, if you're going to do that piece.'
>
> Participant 1036: So it's us fighting to continue to keep the door open and see the drop-in youth clients. (FG 129-2, Phase 2)

In this example, FLS pushed back against a lack of support in order to take the action they believed would promote health equity – in this case to provide services in the community to reduce barriers to access for certain populations. However, not all participants were able to push back against unsupportive managers – some were fully prevented from doing the work they wanted to.

When managers supported or advocated for FLS to do health equity promoting work, sometimes in the face of organizational challenges, managers were described with positive affect. In contrast, managers who were perceived as not supporting FLS to promote health equity were described with negative affect. The previous quote, where FLS characterized their managers as insensitive opponents, is an example of this negative affect.

When FLS understood managers to support their ideas about health equity, managers were often included in the 'us' FLS used to describe local teams. This closeness and identification were particularly evident in discussions about how managers were constrained by even higher levels of management, as in this example:

> That’s where I see health equity is becoming a struggle with us, because then our bosses here, who are very supportive, have to do what comes down from the top. ‘No, I know that’s better, it worked, we all know what’s better but we’re bound by what we’re told.’ (Participant 175, FG 113-2, Phase 2)

Note the difference between “our bosses” and “the top” in this quote; this begins to suggest that there was a difference in FLS’s perception of and identification with these different levels of management. I will return to this point in the next chapter.

Participants in both phases had mixed perspectives on how managers impacted their ability to promote health equity, most saying that managers were supportive but sometimes describing how managers got in the way of activities that FLS felt were ideal or appropriate.

Health system and community service providers enable health equity

FLS also talked about collaborations with health system providers outside of public health and with community organizations:

> To have those partners in place that, we are integrated, because we’ve been referring people for years. I think just because we’re not co-located and, you know, holding hands, we’re definitely integrated. Like we work so well with our partners, we’ll call mental health and be like, ‘I’ve got this person that, you know what? I’ve done their EPDS [Edinburgh Postnatal Depression Scale], it’s really high. I need to get them in to see somebody! Can you help me with that?’ (Participant 1036, FG 129-2, Phase 2)

This FLS described how intra- and inter-organizational relationships supported health equity by making appropriate services more accessible to clients.

Generally, comments about other health system and community service providers were affectively warm and appreciative, and these relationships were clearly valued as part of public health practice to promote health equity. The exception to this was when FLS talked about acute care physicians and nurses, who they often described with disapproval and frustration. Despite the mostly positive affect towards other health system and community providers, they were not part of the ‘us’ FLS used for their local teams and managers.

Chapter summary

In this chapter I outlined two main discourses operating at the micro relational level of FLS’s interpersonal relationships and how these were linked to their articulations of health equity. The first discourse, trusting relationships with clients and communities, asserted that relationships were a foundational element of all health equity discourses, but that these relationships were fragile and therefore required time and attention to create and maintain. The second discourse, supportive organizational relationships, saw team members and other health system and community service providers as generally supportive of FLS’s health equity work. This discourse also saw the backing of managers as crucial to FLS’s health equity work, but FLS said that managers varied in their level of support for the action that FLS wanted to take.

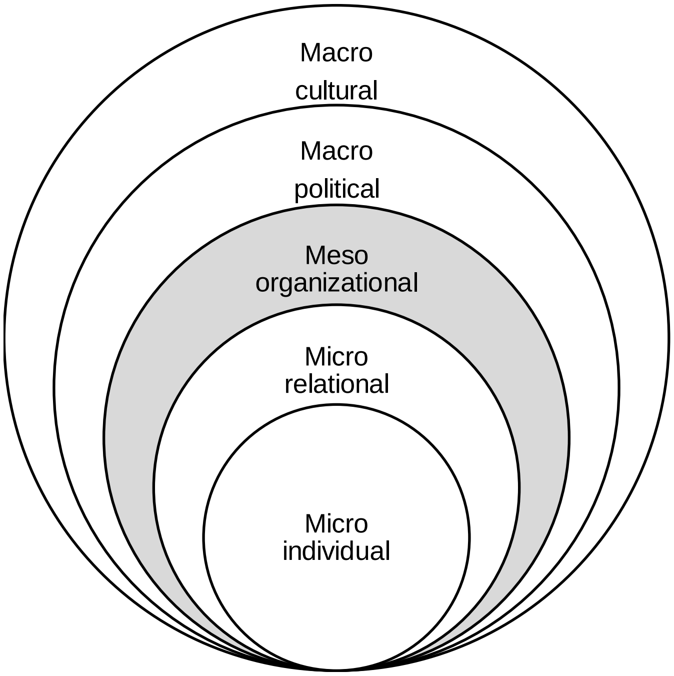
In the next chapter, I move to a broader level of the organizational context to describe the discourses operating at the meso organizational level of FLS’s experiences, demonstrating how FLS articulated how these organizational factors impacted their health equity work.

Chapter Six: Organizational Factors Impacting Health Equity Work

To continue answering the question, *How do frontline public health staff articulate how relational and organizational factors impact their work on health equity, and how did this change over the period of study?*, in this chapter I move to discussing discourses concerning the meso organizational level of FLS's experiences with health equity (see the shaded element in Figure 5). As I showed in the previous chapter, Chapter 5, FLS generally spoke positively about the ways in which the micro relational aspects of their context supported them to promote health equity. Although some FLS reported that the meso level elements of the organizational environment supported them to promote health equity, the dominant discourses among FLS elaborated the myriad ways that the organization prevented them from promoting health equity in the ways they believed to be ideal and appropriate.

Figure 5:

This chapter focuses on discourses that refer to the meso organizational level of FLS's context



I identified seven meso organizational discourses in FLS's talk about their health equity work – four that pertained to organizational conditions and three that described organizational dynamics. I define organizational conditions as material aspects of the organizational environment shaped by policy decisions made by specific actors in that environment such as resource allocation, scope of professional practice, program structures and program priorities. I define organizational dynamics as particular elements of relationships between actors in the organization, in this case between FLS and other actors in the health authority they worked in.

The first four meso organizational discourses I will introduce in this chapter name major organizational conditions that FLS said shaped their ability to promote health equity in their practice: 1) scarcity, 2) bureaucratization, 3) too much targeting and 4) fighting to swim upstream. According to FLS, these four organizational conditions worked together to produce a set of organizational dynamics that shaped their experiences of doing health equity work. These dynamics are described by the last three discourses: 5) divergent priorities, 6) bottom level vs. higher ups, and 7) navigating constraints.

Scarcity

The discourse of scarcity was a key organizational condition discussed by FLS. This discourse reflected FLS's frustration that the organization did not provide enough of the organizational resources they felt were needed to promote health equity. The discourse of scarcity was made up of four themes: not enough programs and services, not enough time for health equity work, not enough resources to support programs, and not enough funding for health equity. In this section I describe each of these themes and then discuss how, together, they produced the discourse of scarcity.

Not enough programs and services

Many FLS described substantial gaps between the needs of clients and the public health programs and services available to meet those needs. FLS identified a number of programs they found lacking, for example:

> What about providing birth control for free to people? What about looking at harm reduction? What about all those other pieces?… What is [the health authority] doing to help in that regard? And how are we making ourselves accessible to people that really need us? (Participant 159, FG 106, Phase 1)

Many FLS mentioned that public health lacked specific offerings like an outreach team or co-located services to meet the needs of clients who faced barriers to accessing public health units. Others talked about the lack of services for specific populations such as youth or adults. One noted, “I think that there’s some attempt at equity in prenatal-postnatal and children up to, what? Age five, probably? But outside of those, it doesn’t seem like there’s a lot of effort to even address the needs of those populations” (Participant 1002, FG 120-2, Phase 2). The impact of inadequate programs and services on health equity was mentioned in both Phase 1 and 2.

In addition to what FLS saw as an ongoing state of inadequate services, a number in both Phase 1 and 2 said that the organization had recently been cutting public health services and programs even further instead of bolstering them with more resources. Cuts affected public health activities like outreach and community development as well as specific programs such as speech language pathology and dietetics:

> Participant 1046: And there’s been some big changes in programming and in services over, what? The last couple of years, handful of years, that have made it even more...
>
> Participant 1044: Even harder.
>
> Participant 1046: …glaring to us. You know, not being able to refer a kid with speech

> problems is probably our best example. [Laughter] (FG 129-2, Phase 2)

FLS expressed frustration that the services they perceived as integral to promoting health equity were seen by higher level decision makers in the health authority as ‘extra’ and thus disposable. They also feared that the health equity promoting services they currently managed to offer would be cut in the future, as this team describes:

> Because it’s not supported from high up. It’s not one of our key mandates. And then, it’s like we looked at with the [outreach program], all of that adult outreach, it would just- it could just drop. It feels very tenuous because it’s not a regular program on public health. (Participant 137, FG 109, Phase 1)

In this case, offerings such as this outreach program, which FLS had created in response to seeing certain populations experiencing barriers to access, were not within the ‘core’ set of programs public health was mandated to deliver, and therefore were at risk of disappearing. I will return to this notion of health equity as extra later in this chapter.

FLS in both phases talked extensively about lacking the time to engage in extra activities that promoted health equity and asserting that these programs were the first to be cut. Discussion about cuts to services were widespread in both phases, as was FLS’s general sense of the tenuousness of public health programs and services oriented towards health equity.

As the examples above have shown, FLS felt that service gaps primarily impacted health equity as access to services and health equity for vulnerable populations when a lack of targeted services (e.g., for youth) meant that individuals or specific populations could not access more services to meet their higher needs. The understanding that a scarcity of programs and services decreased health equity and FLS’s frustration and hopelessness about gaps in service was common in both phases.

Not enough time for health equity work

Although discussions about gaps in programs and services were common, FLS talked even more frequently about lacking the personnel and the time necessary to ensure health equity as access to services. They repeatedly described themselves as being “stretched very thin” (Participant 199, INTV 118, Phase 2) – having too many responsibilities and not enough time. “There’s only so many of us, and so many hours in the day, and our groups get full,” (Participant 183, FG 114-2, Phase 2), one FLS commented.

A lack of time impeded equality of service access by making it difficult for FLS to offer a baseline of services. However, FLS primarily discussed how it got in the way of equity of service access by preventing FLS from:

> spending time with the people who need more time. We can’t do that, to the extent that really makes a difference.… So, taking them by the hand, taking them to the food bank, going with, being alongside, partnering with people, we can’t, we can’t do that, right now, with the, with the resources we have. (Participant 101, FG 101, Phase 1)

The quote above alludes to the idea I mentioned in the previous chapter that the foundational work of relationship building with clients required time. Another FLS commented:

> That’s the biggest thing for me for health equity, that the person that is the- object of our attention, they should have enough time with us to build a relationship, and to know what their options are, and to be able to make an informed choice about those options, and to be able to access those options. And that process isn’t happening, right? (Participant 1033, FG 125-2, Phase 2)

A lack of time was compounded by a shift in program priorities away from health equity informed services such as outreach, as the following group described:

> Participant 1030: We’ve lost contact, we’ve lost time in the school health program as well. We’ve certainly lost a lot there and we’re trying to somehow rebuild that. Number one, we lost the relationships we had with the schools because they just figured we’ve completely backed out of the schools and now we’re trying to- [laughs]
>
> Unknown: Because we did really, didn’t we?
>
> Participant 1030: Yeah we did to a certain extent.
>
> Participant 1023: We didn’t have time. (FG 123-2, Phase 2)

A few teams described other shifts in program priorities such as being delegated programs previously delivered by acute care providers or having shift schedules rearranged in order to expand client service hours from five to seven days a week, both of which squeezed their time even tighter:

> That program’s been downloaded to us as well, without any extra funding, by the way. And the funding that they had at the hospitals is being kept at the hospital and now we’re doing a lot more adult immunizations for transplants and all that kind of stuff, that is also being downloaded from the hospital onto us. (Participant 1028, FG 123-2, Phase 2)

The downloading of responsibility from acute care resulted in FLS’s time being diverted from the unique roles of public health, which included health equity as a core component. Changes to shift scheduling were only discussed in focus groups in urban areas in Phase 2.

Organizational changes such as these two led FLS to feel that the organization did not value health equity:

> So that’s how I see, [the health authority] or health promotion or public health may sound the word [about health equity] real well but they don’t practice what they are preaching. (Participant 1028, FG 123-2, Phase 2)

According the discourse of scarcity, this lack of value placed on health equity by the health authority made it difficult for FLS to promote health equity in their work.

Not enough resources to support programs

FLS also described how other kinds of resources and supports enabled or constrained their ability to promote health equity through the programs and services they delivered. Unlike service levels and staff time, there were mixed perspectives on the availability of resources to support health equity via programs.

Program materials and equipment. Asked what would help them to better promote health equity, one FLS answered:

> Partly it’s tools, like having a budget or like if we’re going to be in the school, I always say ‘I don’t know what my role as a public health nurse is,’ like I’ve worked in lots of schools for non-profits, but like I don’t have a budget, I don’t have resources, I don’t have a curriculum. (Participant 139, FG 109, Phase 1)

Other FLS said they lacked organizational resources to provide clients with material supports such as free groceries or baby formula coupons, and a few groups described programs they operated that relied on donors external to the health authority to provide these resources. However, many FLS described having access to resources that supported health equity, such as taxi fare to enable low-income clients to attend programs or subsidies for birth control for young clients. The availability or absence of these kinds of resources was discussed in both phases.

A number of groups talked about not having access to adequate cell phones to contact clients. One commented:

> Well, the phones they [the health authority] give us are horrid [others agree]. Absolutely horrid. And I spend a lot of my time texting, which is time consuming, on the old-style

> phones. And I'm thinking I can use my time in such a better way if I could text a lot faster because that's their- the only thing they [clients] can afford, you know, is to communicate in that way. So here I've got this great program that's going to address all these needs, but let's do it in a cheap way and set me up for failure, and clients up for failure as well. (Participant 136, FG 109, Phase 1)

This is a clear example of how a lack of program resources disproportionately impacted clients with poorer SDOH, producing barriers to service access. Cell phones were mentioned as a barrier to reaching clients more often in Phase 1 than in Phase 2.

Professional development. A few FLS in both Phases said that the educational opportunities made available to them by the organization supported them to promote health equity. Phase 2 participants appreciated an Indigenous cultural competency course available to them. One commented:

> Well I know [the health authority], it's important to them for us to get special training. Like we all had to take the Indigenous cultural competency training just to help us be aware. And, you know, hopefully that will help us with our practice with these clients. (Participant 1018, FG 122-2, Phase 2)

Others talked about receiving professional development education on topics such as substance use, harm reduction and school health.

However, some FLS complained that they did not have the time or funding for learning. When asked whether the health authority prioritized health equity, one FLS commented:

> The one thing that we know about health and education and other big things in the province right now, it's always- the sadness is things change all the time, and some things- and then you have cuts or you have changes.… For nursing we haven't had as

> much time to do education, so we can then up our game a bit if you might say that, for our clients.… It's not that they [the health authority] don't want to, I think that they would love to offer that, but it's again- it comes down to budget. (Participant 155, INTV 112, Phase 1)

This FLS linked a lack of opportunity for education to a lack of both time and funding, noting that funding constraints came from outside the organization. This perspective was present in both phases.

Evidence and evaluation. Teams in both phases described how they used evidence to enhance health equity in their practice. A few units noted that the health authority provided them with "local area health statistics", which they used "to take a temperature of where the community is at and what's being done to address some of the concerns among partners and in our practice as well" (Participant unknown, FG 108, Phase 1). A number of teams discussed using the results of the BC Adolescent Health Survey conducted by the McCreary Centre Society to guide interventions. Others described using practice based evidence gathered from interactions with clients. However, a few FLS said they lacked time to review evidence. One commented:

> We don't have the time! We don't have the time. Like, when was the last time that you had time to go and do some research, to research out some peer-reviewed articles or look at your practice from a research perspective, you know? I used to be very good at doing that kind of work, and I used to have time to do that. I don't get that time, I don't get that support anymore, because if there's a spare few moments in my calendar, something fills it. (Participant 1003, FG 120-2, Phase 2)

FLS in both phases discussed how evaluation supported the promotion of health equity by allowing them to see whether their interventions were working and for whom. They also outlined the challenges of evaluating health equity initiatives, saying that evaluation was not adequately supported by the organization:

> Participant 149: Absolutely the evaluation piece, we'd love to spend to more time on it. But we're frontline staff who are going full tilt a hundred and ten percent.…
>
> Unknown participant: Cause that is a piece that [the health authority] doesn't support.
>
> Participant 148: And I think that's a downfall of [the health authority] as well, is not putting in the supports for an evaluation framework, to be able to give us the staffing or expertise that would support a strong evaluation. (FG 110, Phase 1)

These quotes demonstrate that despite FLS seeing them as valuable, evidence and evaluation did not necessarily support FLS to promote health equity when they were limited by other organizational constraints such as a scarcity of time or funding. The lack of adequate resources for the use of evidence and for evaluation was another area in which FLS perceived a disconnect between what they and the organization saw as important resources for the promotion of health equity. I will discuss FLS's perspective on the value of and challenges to evaluation in relation to health equity in more detail in the next section.

Not enough funding for health equity

Another key organizational condition that impacted FLS's ability to promote health equity in their practice was funding – for public health generally and for health equity work specifically.

Public health is underfunded. FLS said that the lack of sufficient services, staff time and program resources for health equity that I have described above was caused by inadequate funding for public health. A few noted that public health had been consistently underfunded compared to acute care:

> Like what do we [public health] get, 5%? And acute care gets 95%. And then if they download this [acute care program to us] and they don't give you any extra money or nurses to go with it then yeah, that's health inequity within the whole [health authority], right? The acute versus the health promotion disease prevention.… So it's tyranny of the acute. (Participant 1023, FG 123-2, Phase 2)

This perspective drew attention to the larger health system and reiterated FLS's argument that the allocation of resources for public health was itself unfair and inequitable. All mentions of public health receiving less funding than acute care occurred in Phase 2.

Inadequate funding hurts health equity. FLS said that the underfunding of public health resulted in a scarcity of staff time for health equity promoting activities. FLS felt that key activities such as spending more time with people who needed more time, relationship building and outreach programs – all of which, as I discussed in this chapter and the last, required staff time – were seen by the organization as 'extra' or 'nice to have', not as core components of public health practice. Many FLS described being explicitly pulled back from extra activities in order to shore up core responsibilities. One commented:

> I've heard that before, through management as well that, we have a limited number of dollars and we have to make them go as far as we can, so we have to distill down the work that [public health] nurses are doing so that we can make sure that those core responsibilities are covered. (Participant 1003, FG 120-2, Phase 2)

This also meant that programs and services informed by health equity were often the first to be cut when funds were limited or when staff time was pulled towards other 'core' work such as responding to outbreaks. FLS in both Phase 1 and 2 talked extensively about lacking the time to engage in 'extra' activities that promoted health equity and feeling that these programs were the first to be cut.

FLS also saw a lack of resources as the recent impetus for what they described as unwelcome shifts in the balance between universal and targeted services, with increased funding and staff time going to targeted services based on ideas about how funds should be used to have the greatest impact. Many FLS alluded to this emerging relationship between funding scarcity and universal vs. targeted approaches, describing the necessity of "doing more with less and targeting our limited resources into those most vulnerable" (Participant unknown, FG 123-2, Phase 2). FLS believed that both cuts to services and reallocations towards targeted services were intended as "cost saving measures" (Participants 144 & 175, FG 113-2, Phase 2). The idea that funding scarcity impelled a shift toward targeted services with a resultant decrease in universal services was common in both phases. I will discuss this shift towards targeted programming in more detail later in this chapter.

What gets measured gets funded. Although funding allocation was for the most part outside of their control, FLS described one way in which they attempted to challenge the underfunding of health equity work – measurement. FLS in both phases said that in part, the lack of funding for health equity work was a result of health equity being "a very complex area to be doing evaluation" (Participant 105, FG 101, Phase 1). The key challenge here was the difficulty of quantifying the impacts of upstream public health interventions, which impact a complex set of relationships between individual and community SDOH. This group explained:

> Participant 189: I just find we have to defend our programs, and it's really hard because we can't put numbers on stuff.… In acute care, you can say, 'you give this drug, and this many people survive'. In public health, we don't have those kind of black and white [others agree]. And studies are tricky.

> Participant 183: You can’t say this person coming and seeing us five times prevented their child dying of SIDS or drowning or something. You can’t say that [others agree]. Even though we may know in our hearts that it probably did [laughs].
>
> Participant 188: We know that our work is important, but it’s like we feel like we have to prove it.
>
> Participant unknown: It’s hard to measure.
>
> Participant 182: Often the studies they do, whether it be reductions in smoking, or seatbelt safety, or helmet safety, or whatever, take a long time to show any type of change within a community as opposed to, like Participant 189 was saying, like with acute care you can usually show progress in a faster manner.
>
> Participant 188: Yeah. It’s difficult to measure, the accuracy. You know, so that’s the thing. And I think that’s part of where all the funding, all the funding goes to acute care, where it should be the other way around. (FG 114-2, Phase 2)

In this conversation, FLS argued that some of the challenges of measuring upstream health equity interventions – the complex interconnected factors, the preventive nature of the work and the long time scale of impact – were part of the reason that public health was underfunded, especially compared to acute care.

Other FLS argued that the complexity of evaluating health equity interventions contributed to these activities being the first to be cut when resources were scarce:

> Participant 159: If we can quantify it with a number, then we can- we can throw dollars at it. If we can’t quantify it with a dollar, then it’s something that’s on the table that can be removed when we, when we do have limited dollars.
>
> Participant 157: Measuring it.

> Participant 159: Yeah, and I think our budgets have been cut back to such an extent that- and we are told as well, 'Well you have to prioritize your work', and I think that that's where you- we pick the things that we can, we can, we can [pause] ease out of the easiest. (FG 106, Phase 1)

Despite the difficulty of measuring the impact of public health work, FLS felt strongly that the health authority got "a big bang for their buck from public health nursing" (Participant 1003, FG 120-2, Phase 2) and for that, public health should be more highly valued and given additional resources.

Therefore, many FLS saw evaluating health equity initiatives as a strategy to "defend [their] programs" (Participant 189, FG 114-2, Phase 2) and combat underfunding. Evaluation was a way to generate evidence to demonstrate the impacts and value of health equity work. FLS hoped that evaluation would allow them to argue for more organizational support for health equity interventions where it was lacking in order to push back against the devaluing of health equity by the organization. This strategy relied on the premise that:

> Participant 105: …money goes to where the numbers are, right? And…
>
> Participant unknown: Evaluation….
>
> Participant 105: …if we can't speak to what we do, and we can't show a result, then we're not going to get- be able to get more funds. (FG 101, Phase 1)

Given the lack of time, resources and expertise in evaluation that FLS in both phases talked about, no teams described successfully using evaluation to challenge the underfunding of health equity initiatives.

Producing the discourse of scarcity

Together, FLS's assertions of inadequate services, staff time, program resources and funding for public health produced the discourse of scarcity. FLS argued that there were not enough resources to provide a basic level of services to clients, to give more to people and populations who needed more, to build relationships and trust with clients or to engage in professional development and evaluation to support health equity. The discourse of scarcity also reflected FLS's worry that even these inadequate resources might get cut. The discourse of scarcity also included the notion that scarcity necessitated a focus on efficiency, or using limited resources to have the biggest possible impact on population health. FLS emphasized what they saw as the unacceptable and unfair nature of this scarcity by comparing the funding available to public health and acute care. FLS saw a scarcity of resources as an inescapable reality of their work; as one said, "we know we don't have enough resource, and that's not going to change" (Participant 105, FG 101, Phase 1).

Bureaucratization

The discourse of bureaucratization articulated another organizational condition that constrained FLS's ability to promote health equity. FLS posited that bureaucratization impeded their appropriate professional scope and autonomy. The discourse of bureaucratization contained two themes: more standardization and less professional autonomy. I will describe each of the themes in turn and then outline how they produced this discourse.

More standardization

A common theme in Phase 1 was the rise of standardized public health programs. One FLS described this recent trend:

> They're trying to put everything the same, across the board and taking away the individuality of the community. So therefore, health equity is going down the tubes a bit because we're not allowed to custom design as much because of the money saving

> ventures. (Participant 175, FG 113-2, Phase 2)

This FLS described how organization-wide initiatives to standardize public health services across the health authority decreased the autonomy of local teams to tailor programs to community needs, which was important for health equity.

Standardization made FLS feel that the health authority did not value the work they were already doing to promote health equity and that the 'extra' work they had been doing would be the first to face cuts. These FLS explained:

> Participant 144: And when I listen to the part about not- I guess higher-ups hearing what's happening in [our town], just when you think of the regular economic climate going on, that 'Oh here, [town] is doing this good job, no one seems to be recognizing it'. And because there's a push to be uniform that, 'Oh, if they're not listening to what we're doing here, then is something going to get cut?' Like just listening to that, to me, it's just like, oh my gosh.…
>
> Participant 149: We've been able to do our own little thing, we're like a little wildfire-flower- out in the- but at the same time we're worried that someone's going to come along and say, [in a character voice] 'You don't look the same as all the other dandie'- or whatever. Daisies or whatever. (FG 110, Phase 1)

Both quotes above demonstrate that FLS often linked organizational standardization to a "regular economic climate" of funding scarcity through the premise that tailoring services, which they argued promoted health equity, was more costly than delivering a core set of programs across all public health units.

Some of the moves toward standardization that FLS described were due to the implementation of specific public health programs. Despite being seen by some FLS as an indication that the health authority was prioritizing health equity, many participants in Phase 2 said that new standardized perinatal programs had introduced more rigidity into how they were permitted to work with individuals and families. These new programs involved ‘ticky boxes’, a term which many FLS used to pejoratively refer to the assessment forms used to determine client eligibility as well as to the broader logics underlying these programs. FLS felt that ‘ticky boxes’ took away from the relational orientation that was so important to health equity. This FLS illustrated that critique, saying:

> It almost feels like we’re losing a bit of that [relationship building with clients] with these ticky sheets and stuff, you know? And trying to fit people into boxes. We’re losing some of that. Although verbally they’re saying, you know, we should be doing patient-focused care and we should be doing blah, blah, blah. We lose the ability to do that as we’re getting more and more structured and stuff. (Participant 1031, FG 125-2, Phase 2)

In this quote, relationship building and highly standardized programs were understood as antithetical.

The discourse of bureaucratization was informed by FLS’s perception that the standardization of public health programs, especially ones that structured their interactions with clients and left little room for relationality and tailoring to context, limited their ability to promote health equity. Comments about increased uniformity of programs happened in Phase 1 and frustration with increasingly bureaucratic processes of client assessment were more prominent in Phase 2, suggesting that there may have been two distinct organizational moves that resulted in increased standardization.

Less professional autonomy

Professional autonomy was a topic of some emphasis in the focus groups, with FLS reflecting on their ability to engage in tasks and make decisions without oversight from management, and the resultant impacts on health equity. This FLS described what that looked like:

> [In my previous job] there were [soft chuckle] sort of guiding principles in place and general, you know, 'We'd like you to hit this target and this target, and then go ahead and do your work!' And here, it's, 'You need to spend this amount of time doing this and you need to fill out this paperwork to do that'. (Participant 1003, FG 120-2, Phase 2)

Many FLS said that their activities had become very 'prescribed', in that they received excessive direction about specific tasks they were required to complete instead of spending their energies where they saw fit.

Most felt that their autonomy had eroded over the past 5-10 years, as these FLS explained:

> Participant 1042: There was a time that public health nurses were more into going rogue and doing their own thing. But really, things have tightened up, and you know, there's more of a magnifying glass on what we're doing with our time and our, you know? We're not able to do some of those things that we always really liked to do. I know even when I worked as a public health nurse down in [town], you know, there were a lot of restraints suddenly put on us. Different groups we used to attend and support, and then it was all kind of reined back into, you know, putting us into little boxes.…
>
> Participant 1041: And I think that same shift, because I've been in public health for probably, just about eight years, and the support and that piece was there eight years ago when I started.
>
> Participant 1044: It was, yeah.

> Participant 1041: And now it’s not. (FG 129-2, Phase 2)

FLS resented that this “magnifying glass” meant they increasingly needed to justify and request permission to tailor services to clients and to engage in extra activities that did not fall within their core responsibilities, as these FLS discussed:

> Participant 157: Permission to be in school, permission to be out in the community, permission to be out at outreach.
>
> Participant 159: It’s funny that you say permission because we never-
>
> Participant 156: But I feel like it’s not. We don’t have permission to go to home visits so much anymore.
>
> Participant 159: No, but isn’t that funny that we use that word now because you know, five years ago it wasn’t about ‘permission’, you saw a need, you dealt with it.
>
> Participant 156: Now it’s not. (FG 106, Phase 1)

In this case, the extra activities that FLS needed permission to do were activities that FLS across the focus groups described as part of health equity-promoting practice such as outreach, community-based service provision and home visiting.

While the quotes above speak to some FLS’s general sense that their autonomy was being eroded over time, others felt that standardized public health programs were the culprit, as this FLS argues:

> We used to, as Participant 1017 said, just to add on to that, autonomously, where we had a case load of clients that we kind of in our own mind, even before we knew about [the perinatal program’s assessment criteria], we just knew how, you know, which families we were going to spend more time with, or you know.… And now, yeah, it’s quite different. Like, as far as who can have a home visit and they have to meet certain criteria.

> Whereas we would just go, if someone was having a hard day and they were crying and needed to see- we just went! Whereas now we have to justify, why we go. (Participant 1020, FG 122-2, Phase 2)

The last three quotes have emphasized FLS's sense of a discrete organizational change over time that had the impact of decreasing their professional autonomy. Many FLS experienced the overall increased rigidity and decreased autonomy as a loss, and said it impeded their ability to promote health equity. Some found the control over their day to day tasks and decisions insulting and wished that the organization had "more confidence in [their] abilities and professionalism and education and experience" (Participant 1001, FG 120-2, Phase 2).

On the other hand, a few FLS discussed how they still had a level of professional autonomy, even in the face of increasing standardization, which supported them to promote health equity with clients. Autonomy supported equity of service access when it allowed FLS to 'spend time with people who needed more time'. For example, despite certain programs having structured assessment criteria, FLS in some teams were given the autonomy to follow up with clients who they independently assessed as needing more services and to tailor services to those clients, as this FLS described:

> We're pretty lucky here in that, you know, when all of this stuff came down, it was fairly clear, all these ticky lists [assessment forms], you can still use your nursing judgement. Our managers, our supervisors always said. (Participant 1031, FG 125-2, Phase 2)

In other cases, providers were explicitly given autonomy by local managers or their scope of practice to find solutions to gaps in service, as in the following example:

> When we have outbreaks in our vulnerable populations, then we work with CD [communicable diseases] in [town], and- it's nice we're able to be creative in solving the

> issues. Like we can go into homes and vaccinate. We can- we'll, maybe- one time come in on a Saturday because we work with how the- what's available, you know. It's not rigid, here, when we have an issue, we look at it and figure out, we have that freedom to say, 'Okay, well let's go out in the community', especially with the outreach team. (Participant 143, FG 110, Phase 1)

This latitude to use practitioner discretion to respond creatively to local issues or to decide which clients to spend more time with was celebrated by FLS as an important way to mitigate the impacts of other organizational constraints on health equity work and, as I mentioned in the previous chapter, relied on the support of local managers.

Producing the discourse of bureaucratization

FLS's talk about the standardization of health equity within public health practice and limited professional autonomy produced the discourse of bureaucratization. This discourse contended that the historical principle of provider autonomy in public health was in jeopardy due to organizational trends that shifted public health practice, and along with it, health equity informed practices, to be more regimented and controlled, with more prescribed direction and oversight of FLS's work as well as more structured approaches to that work.

Too much targeting

In Chapter 4, I demonstrated that the discourse of equity of access to services and the discourse of health equity being for vulnerable populations posited that focusing more time and attention on clients and populations with more needs or more barriers to services would contribute to decreasing health inequities. I also described a counter-discourse of individual needs that pushed back against systemic articulations of health equity under the premise that the categorizing logics central to discourses of equity and vulnerable populations actually reproduced inequities. In addition, I discussed how equality and equity were conceptually linked by FLS to universal and targeted approaches to public health practice. In this section, I will show how these discourses and some of the interactions between them manifested in the third discourse in this chapter describing organizational conditions impacting health equity work, the discourse of too much targeting.

In previous sections of this chapter, I began to discuss how some FLS articulated how funding scarcity was causing shifts away from universal and toward targeted approaches to public health and how FLS saw this as a loss for health equity. Many FLS believed that the balance of public health programs and services in the health authority had become skewed towards targeted approaches informed by the discourses of equity of access to services and vulnerable populations. This resulted in increases in barriers to service due to a loss of equality-informed universal programs, with consequent negative impacts on clients' health outcomes. As one FLS commented, "Part of the moves in public health concern me in that we might be getting away from some of the general prevention for the entire population and I think public health shouldn't lose that" (Participant 189, FG, 114-2, Phase 2). These FLS believed that equity was impeding equality, specifically, that an increase in equity-informed programs and services was pushing equality of service access below an acceptable threshold. The discourse of too much targeting manifested most often in vigorous critiques of the health authority's attempts at formalizing equity through targeted perinatal programs. In the following sections I will provide an overview of the key themes in this discourse: targeted perinatal programs are about equity, universal and targeted programs are out of balance and too much targeting is unfair.

Targeted perinatal programs are about equity

A significant proportion of public health service provision in BC at the time of data collection (Phase 1 data was collected in 2014 and Phase 2 in 2015) involved maternal, infant and child services, based on the premise that "perhaps the most fundamental underpinning of good population health is to ensure that infants are born healthy and that their development in the first few years of life is healthy" (Ministry of Health Services, 2005a, p. 24). Public health partners in the ELPH study identified that mental health promotion and the prevention of the harms of substance use programming – the program areas that this study focused on – was often delivered via maternal, infant and child services.

A cornerstone of maternal, infant and child services, as described by participants, involved providing home visits to parents during the perinatal period to perform assessments, check developmental milestones, and identify any other issues for which the family needed support. Based on ideas of equality and an entitlement to a base level of services, FLS noted that "universal home visitation… was a big tenet of public health in the past" (Participant 1016, FG 121-2, Phase 2).

However, in the years prior to data collection, new perinatal programs were introduced that increased enhanced or targeted services for families who were identified as being at risk for poor maternal and child outcomes. Some of these programs were mandated by the provincial Ministry of Health to be implemented in most health authorities (Anonymous, personal communication, June 27, 2022; British Columbia Ministry of Health, 2011). This meant that every public health unit in the health authority was required to deliver those programs, although units were permitted some flexibility in their approach. Evaluating eligibility for these programs involved FLS completing assessment forms that asked about health status (e.g., mental health), behaviours (e.g., substance use) and social determinants of health (e.g., income) of clients. The results of assessments were used to assign clients to a high- or low-intervention program stream.

Parents who were assessed as being ‘at risk’ were eligible for more intensive interventions, such as mental health services or baby groups. Parents who did not meet the program criteria were served by less intensive universal programming. As a result, home visits were now only provided to certain clients, as this FLS explained:

> But even the province is kind of changing our focus that way. Like with our mandate on home visitation, we used to be a universal program, and now it is much more targeted in terms of home visitation, you have to meet criteria and those criteria are those that are the descriptor of ‘vulnerable’.… We offer services, enhanced services to that group, as opposed to the reverse of that, people who on paper seem to be quite well-adjusted and maybe not at risk, we don’t offer them that enhanced service. (Participant 1016, FG 121-2, Phase 2)

FLS understood targeted perinatal programs to mobilize the discourse of health equity as equity of access to services, in that people with higher needs were entitled to more services. They also understood the programs to rely on the discourse of vulnerable populations, in that clients were assessed as either ‘vulnerable’ or ‘not vulnerable’ based on their experiences and/or social categories. These two discourses were formally embedded in perinatal programs via assessment forms and program streams. Targeted perinatal programs mobilized the health equity discourses related to service access only; the programs did not attempt to address inequities at a structural level.

Universal and targeted programs are out of balance

In Chapter 4 I described how the discourse of individual needs offered a conceptual critique of systemic articulations of health equity found in the discourses of equity and vulnerable populations. In this chapter I turn to critiques of the discourses of equity and vulnerable populations related to the organizational environment. As I mentioned earlier, some FLS believed that targeted programs were laudable interventions created to promote equity of access to services. However, many FLS in both phases referred to these programs to articulate their critiques of how the health authority was shifting the balance of public health programs and services too far in the direction of equity, to the detriment of equality.

There were differences in FLS's perspectives on targeted perinatal programs between Phases. In Phase 1, which took place a year or two after some units implemented these programs, FLS were adamantly opposed to them and only a few saw them as a valuable way to promote health equity. In Phase 2, opinions were more mixed. Although some still opposed the programs entirely, others saw them as valuable initiatives to promote health equity among their clients and as evidence of the health authority's commitment to and value for health equity, suggesting a shift in perspective over time.

FLS's frustration with targeted programs was exacerbated by the organizational context of inadequate funding that I discussed at the start of this chapter. Although public health units were mandated to deliver targeted perinatal programs, no additional resources were provided to implement the programs or deliver more intensive services. Therefore, in order to provide more services to clients with higher needs using the same level of funds, units had to carefully balance universal and targeted services. These FLS skeptically described this dynamic:

Participant 1013: I think the thought is, if we shift our service more…

Participant 1016: …the money will shift.

Participant 1013: …to the more high-risk.

Participant 1016: Somehow the money shifts somehow. It's a reallocation. [laughs]

Participant 1013: Yes, and we're not providing universal service, that should pay for

> itself. Right? (FG 121, Phase 2)

In this way, services premised on equality (universal) and equity (targeted) were characterized by FLS as being in a zero-sum game under an overall climate of funding scarcity. Some FLS felt that this shift from universal to targeted contributed to the "erosion of universal services" (Participant unknown, FG, 123-2, Phase 2). In order to deliver mandated perinatal programs, some units pulled resources out of universal services, which meant that many stopped offering universal home visits. In both phases, FLS worried about the balance tipping too far in favour of targeted programs and away from universal services.

Targeted perinatal programs even pulled resources from other targeted programs such as outreach, as one FLS described:

> I think part of it is that it isn't supported from high up- it's not like they were sneaking around and doing [the outreach program], it's just like 'Sure, if you find some extra time, then go and do it, but good luck in finding the extra time' [laughs]. And now we're getting to the point where we have all these other programs going on that, that are- [the targeted perinatal programs]- like that are mandated. So that extra time is shrunk and now the clawing back it feels like is beginning over the last year or so I'd say. (Participant 137, FG 109, Phase 1)

This comment demonstrates FLS's frustration that more structured programs were taking resources and organizational emphasis away from locally tailored services that had been created to meet community needs, in a way that linked the discourse of too much targeting with the discourse of bureaucratization.

Drawing again on the discourse of scarcity, many FLS saw increased (or rather, too much) equity as pushing equality below an acceptable threshold, as this discussion illustrates:

> Participant 152: I think the one big difference with this health unit is that there’s the same amount of emphasis put on the enhanced services as the universal. Where I think, some of the other health units, I won’t speak for all of them, but some of the other health units are starting to put more of an emphasis on the enhanced services and less on the universal. So they’re dropping that piece, whereas this health unit is maintaining both of them.
>
> Participant unknown: Equality.
>
> Participant 148: Equality. (FG 110, Phase 1)

This last quote suggests that even the FLS who critiqued targeted programs still saw a place for them in public health. However, the key issue was not whether targeted programs should exist, but with the balance of resources and organizational emphasis devoted to targeted vs. universal support.

The shift in funding away from universal programs created a situation where clients who did not fit into the ‘vulnerable’ category according to assessment forms were not eligible for targeted services but were also not able to access ‘eroding’ universal services and thus, as this FLS explained:

> I think the people that don’t hit the box [fit the eligibility criteria] can fall through the cracks. [agreement from others] And I just remember the student that came in to do a presentation with us and she was, I think a second-year nursing student and had had a conversation with a mom about her postnatal experience and she hadn’t been offered a home visit because this was her fourth child and all the boxes were ticked as okay. But, for her, she was really struggling and she commented to the student that she was missed and would have really benefitted from having public health nursing services in her

> vulnerable period. But she didn't hit the marks so she wasn't picked up through the screening. Whereas, when we were going into homes and providing everybody the opportunity to have a home visit, we would have found that person just through our general client contact with them. (Participant 1003, FG 120-2, Phase 2)

Universal programming was seen here as a valuable way to promote equity of access to services *via* equality of access to services because it enabled FLS to identify clients with more needs that were not immediately apparent in screening processes or on assessment forms.

FLS experienced the decrease in equality as a loss that they resisted, as they described here:

> When [our universal perinatal program] had to go… that was a glitch for a lot of us to be able to say- we fought it for a little while as best we could- but we were really into that equality, I guess, if you want to say that, I don't know- that everybody has access to something no matter their-.… And that's kind of the directions things are kind of going, and so for a lot of us, I think- for me, I can speak for myself, it's been very difficult to swallow. (Participant 155, INTV 112, Phase 1)

This quote clearly speaks to the emotional impact of health equity related organizational dynamics on FLS, which I will discuss in more detail later in this chapter.

Too much targeting is unfair

A few FLS went so far as to frame too much emphasis on targeted programs as 'unfair', as this quote illustrates:

> I think health equity to me is just making sure that it's fair access to all, not just to certain people.… That's the kind of stuff that I get frustrated with because, especially with our new [targeted perinatal] program where we have to put everybody in a box and if you

> don't fit the box then you don't get seen, it's unfair, it's unequal. (Participant 1028, FG 123-2, Phase 2)

This quote demonstrated a strong attachment to equality of access to services, with the participant arguing that differences in service availability based on certain criteria (which mostly relied on social categories) that were characteristic of targeted services were 'unequal' and therefore 'unfair'.

According to some FLS, an excessive emphasis on equity of service access and a focus on vulnerable populations 'marginalized' clients who did not fit criteria based on social categories. One FLS shared a personal story of seeking and being refused postnatal services as a client:

> I even came down to the office one day and asked to see a nurse… and she said, 'You're doing too well and you can't come to group'. So I was really marginalized, even when I went seeking for the help I couldn't have it. So when you don't fit into the young teen mom, Aboriginal, not doing well, refugee, you get almost no support. (Participant 1021, FG 123-2, Phase 2)

These last two quotes are examples of how discourses of equity and vulnerable populations were seen by some FLS as unfair and marginalizing in the organizational context, whereas discourses of equality were seen as fair. These arguments drew on the discourse of individual needs, critiquing attempts to systematize understandings of and responses to inequities and instead arguing that any systemic approach to health equity *produced* inequities. The quotes also illustrate how language that is usually intended to focus attention on systemic injustice such as 'marginalized' was coopted by FLS to draw attention away from systemic analyses and towards individualist claims of what comprised appropriate action on health equity.

Producing the discourse of too much targeting

According to FLS, targeted perinatal programs were informed by discourses of equity of access to services and vulnerable populations. FLS argued that there was value to both targeted programs informed by the idea of equity and universal programs informed by the idea of equality, but that there was an appropriate balance between the two. The discourse of too much targeting asserted that this balance had tipped too far in the direction of targeted programs, and that this had a negative impact on clients, primarily because it pushed universal services below an acceptable threshold. This resulted in FLS framing systemic approaches to health equity such as these new targeted programs as unfair.

However, FLS's perception of how targeted programs negatively impacted clients was also a product of the specific organizational conditions of scarcity and bureaucratization – scarcity required public health units to shift funding away from universal programs in order to deliver mandated targeted programs and bureaucratization decreased FLS's ability to serve clients who did not meet highly structured assessment criteria using their professional discretion. Therefore, despite many FLS valuing the idea of equity in principle, in the organizational environment, due to specific conditions that affected their work and thereby their clients, many felt there was too much emphasis on equity, and that equality was losing ground. Some aspects of the discourse of too much targeting drew on the discourse of health equity as being about individual needs, producing a resistance to or rejection of systemic approaches to health equity. I will return to the risks of the relationship between these two discourses in the Discussion.

Fighting to swim upstream

In Chapter 4, I showed how FLS mostly articulated and took action on health equity through the discourse of health equity as access to services instead of through the discourse of health equity as structural, and the organizational factors I have discussed so far in this chapter primarily impacted health equity as access to services. FLS's emphasis on access to services may have been in part because a limited professional scope prevented them from promoting more structural articulations of health equity through the upstream work of community development and policy advocacy. This limited scope was the central premise of the last organizational condition, the discourse of fighting to swim upstream.

Some FLS noted that working structurally fell squarely outside the scope of their practice. In the words of one:

> I think our scope is like- if we're just at the [community service provider] to immunize people, then we're not involved in their lives in the same way where you're hearing some of the more complex pictures about- like, so you're always putting the Band-Aid on as opposed to working community wide to try and sort- because we know housing makes such a difference or we know that- like any of those things. (Participant 139, FG 109, Phase 1)

Although this FLS saw the interconnections between SDOH and health as deeply pertinent to health equity, she was not able to intervene on them at a structural level.

Some of the organizational elements I have already discussed such as a lack of time contributed to this limited scope. As I described above in relation to their diminishing autonomy, FLS described facing increased pressures over the previous 5-10 years to complete prescribed service provision tasks instead of working on upstream initiatives. This conversation illustrates that change:

> Participant 139: I also feel there's a different crunch on our time. I feel like 10 years ago, there was more community development encouraged and supported as a public health

> nurse, and we would have a voice around things like, housing or just some of the things. And our time has been so prescripted [sic] in a different way.…
>
> Participant 1004: And eventually it gets whittled down to focusing on more acute things, instead of our overarching, what should be goals of health promotion and prevention.
>
> Overlapping: Promotion and prevention.
>
> Participant 1007: It says that on our name tag. (FG 119-2, Phase 2)

Despite bring professionally responsible for "health promotion and prevention", these FLS did not actually have the time or scope to do this kind of work. FLS felt that with all the client service tasks they had to accomplish, they did not have time to engage in community development activities such as community meetings, coalitions and collaborative initiatives, or to advocate to government in order to decrease inequities in SDOH at a larger scale.

FLS also felt that the organization did not support them to do upstream work, and they sometimes struggled to get permission to do this work from management. These FLS described the joint constraints of time and organizational support:

> Participant 1002: I don't know if it's provincially or just here, but we don't do a lot of anything with that, that I see. Like, trying to advocate for better housing or food or access to food, or anything. We're just…
>
> Participant 1003: We don't have time for that either.
>
> Participant 1002: No.
>
> Participant 1003: Like, it's not something that seems to have much value in, not that we don't see a value in it, but that we don't seem to have employer support for that.
>
> Participant 1002: No, to even look at it or raise those issues is not really- we're getting more and more focused on very individual…

> Participant 1003: Tasks!
>
> Participant 1002: …tasks. And care with one-on-one. And that is my concern, is that if you get- it's very time consuming. So then there's nobody left doing the upstream work at- looking at how you do decrease the inequities. (FG 120-2, Phase 2)

These FLS felt that work to promote health equity as structural was not valued by their employer. In this example the 'employer' was not local level management but higher level managers who set priorities and created structures that governed how FLS engaged in professional activities.

A number of FLS noted that witnessing the impact of SDOH on their clients' lives and being unable to address it at a structural level made them feel powerless. One commented:

> Hearing families' stories and seeing the impact on them, and the powers that be, the infrastructures of the government, and the policies, and the bureaucracy. It's really difficult to make any real change in their circumstance to help them with housing.… So you see it, and you would like to help bridge that gap, but it's pretty hard. I don't have the power or tools myself to address it. (Participant 1012, FG 121-2, Phase 2)

Together, constraints related to scope, time and autonomy resulted in many FLS feeling that "it takes a lot of energy to keep fighting, swimming upstream" (Participant 156, FG 106, Phase 1).

The FLS who noted that SDOH work was "not on [their] table" (Participant 139, FG 109, Phase 1) strongly believed that this should not be the case in public health:

> Public health is traditionally about health advocacy. And that's one thing that we would like to see more, instead of us being, you know, doing the tasks that we tend to do, to be able to be at the table and be able to advocate more and to be able to be part of policy development. (Participant 1039, FG 129-2, Phase 2)

This FLS reiterated the notion from within the discourse of bureaucratization that ‘tasks’ were taking away from ideal health equity action as well as diverting FLS’s work away from the “traditional” structural level role of public health.

Some FLS believed that having more staff or more time (which would require more funding for public health) would allow them to work upstream. However, for one group, expanding their scope of practice was just as important as more staff time:

> Participant 187: We almost need like another position, or two, maybe two other nurses. And those two nurses do community development for like one or two years, and we all rotate through that.
>
> All: Yeah!
>
> Participant 187: So that we can build those relationships, and build those, like, upstream initiatives. Because the cynical part of me is like, well, add two nurses and then we’ll all be still tunnel visioned. [Laughter]….
>
> Participant 187: Whereas, like, we want those two nurses to be able to actually, like…
>
> Participant 189: Make a difference.
>
> Participant 187: …work on affordable housing or whatever. (FG 114-2, Phase 2)

This comment links the discourse of fighting to swim upstream to the discourses of scarcity and bureaucratization.

Almost all discussions about constraints to working upstream happened in Phase 2. In Phase 1 there was some talk about limitations to community development work but very few mentions of limitations to policy advocacy work. This aligns with my finding in the previous chapter that more FLS in Phase 2 than in Phase 1 articulated health equity as structural, even if in Phase 2 they were still mostly unable to translate those articulations into action.

Divergent priorities

So far in this chapter I have laid out four key discourses about the organizational conditions that impacted FLS's ability to promote health equity in their practice: scarcity, bureaucratization, too much equality and fighting to swim upstream. Throughout the chapter I gave examples of how the four discourses were interwoven. For example, funding scarcity was a factor in FLS feeling that the balance of universal and targeted had tipped too far towards targeted programs. Bureaucratization contributed to FLS not having the scope to work upstream.

These four discourses operated jointly to produce a set of organizational dynamics that shaped the health equity work at the frontline. In this section I introduce the last three meso organizational discourses, each of which describe a different aspect of the relationship between FLS and other actors in the health authority: divergent priorities, bottom level vs. higher ups, and navigating constraints. In presenting these discourses, I widen the socioecological frame of analysis slightly from a focus on the specific conditions affecting FLS's practice to the broader dynamics that were collectively produced by and cut across those conditions. The first organizational dynamic I will present is the discourse of divergent priorities.

A small minority of FLS felt that commitments to health equity had been articulated at the highest levels of the organization, mentioning guiding documents created by the health authority such as a statement of values that outlined or implied a commitment to health equity. A few others saw evidence of the prioritization of health equity in organizational support for certain programs, as this group described:

> Before it was always just the nutritionists and a few other frontline staff talking about food security at a community level. But then when it came down from the province as a real key initiative, as something that each health authority had to have, and then it

> became a core program within all of our work. Now I feel it's much more integrated within everything we do.… And I see, you know, food security was one, and now I see health equity is another one that's coming forward.… You know, the recognition from an organizational level coming down to initiatives on the frontline, showing that health equity is being considered and all of these things are being integrated, right, within our work, our policies, our guidelines. (Participant 105, FG 101, Phase 1)

This quote was the only allusion to the *Framework for Core Functions in Public Health* (Ministry of Health Services, 2005a) in either phase.

Despite a few comments like this, the discourses I have presented so far in this chapter have implied that for the most part, FLS believed that the health authority did not value or prioritize health equity in the ways FLS believed was ideal. FLS said they needed certain resources to promote health equity, but the health authority underfunded and sometimes cut resources for health equity work (the discourse of scarcity). FLS saw their ability to tailor interventions and their professional autonomy as essential to meeting the unique needs of individuals and communities, but this latitude was being eroded by mandated programs and prescribed tasks (the discourse of bureaucratization). Some FLS felt targeted approaches to services were extremely valuable for health equity, but were frustrated that new mandated programs resulted in people who needed services not getting them (the discourse of too much targeting). Some saw upstream community development and policy advocacy as essential to shifting the structural determinants of health inequities, but their professional scope was restricted to downstream service provision (the discourse of fighting to swim upstream). In each case, most FLS were adamant that their values and priorities related to health equity diverged from the values and priorities of the organization they worked for. The rest of this section illustrates how the discourse of divergent priorities manifested in FLS's talk.

As I have shown throughout Chapters 4, 5 and 6, for the most part FLS were emphatic that they, as individuals and as teams, valued health equity and prioritized it in their practice. However, when asked whether the health authority prioritized health equity, most FLS disagreed, many with sarcasm and derision. This group's response is a good example of that reaction:

> Interviewer: To what extent would you say that kind of thinking, which we'll just call health equity for now, to what extent would you say that's a priority in, you know, outside of your health unit, say in the health authority?
>
> Participant 149: Oh, in the health authority?
>
> [Pause. Group bursts into laughter]
>
> Participant unknown: Well, even like-
>
> Participant unknown: Who's going to touch that? [Lots of laughter] (FG 110, Phase 1)

All FLS agreed that official recognition from the top levels of the organization was extremely important to allow FLS to promote health equity at the frontline.

FLS pointed to the scarcity of resources and tools to support health equity in their day to day practice as evidence that the health authority did not prioritize health equity:

> [A budget and resources come] with support from, like, like, you know, official kind of statement that we provide care to outreach at somewhere like [addictions service provider], at somewhere like [HIV service provider], at somewhere like- So it becomes- every health unit bears that responsibility to try to meet that population's needs, which we don't have now. That's not an official public health [health authority mandate] that we actually do that, right? [Others agree] And, when you publicly officially say that you're going to do that then hopefully some FTE [full time equivalent staff] comes with

> that so that you can actually do that. (Participant 140, FG 109, Phase 1)

This scarcity of resources combined with a lack of explicit organizational commitments to health equity, in the words of one FLS, "just makes you feel like the priorities of people above you, like Participant 187 was saying, are not what our priorities are" (Participant 183, FG 114-2, Phase 2). This sentiment was the touchstone of the discourse of divergent priorities.

However, some FLS noted that even when the organization had articulated commitments to health equity, this had not translated into resources 'on the ground'. This group highlighted the discrepancies between the health authority "talking the talk" and "walking the walk" (Participant 159, FG 106, Phase 1) in relation to health equity:

> Interviewer: Do you feel that [the health authority] itself as an organization makes health equity a priority? Or, do you see it anywhere in any documents, or-?
>
> Participant 1016: I think that they have intention to promote health equity. Now do they give us the tools and resources to be able to deliver it?… They talk about equal access, they talk about being in touch with our own- doing some self-reflection before dealing with clients, during client interaction. All of those things, theoretically, are all there. But they don't always give us the tools to deliver the service. (FG 121-2, Phase 2)

FLS did not always attribute the discrepancy between 'talk' and 'walk' to nefarious intent on the part of the organization; in the words of one group, "they *think* they are" (multiple participants, FG 114-2, Phase 2) prioritizing health equity. Still, this talk vs. walk perspective was common among FLS, many of whom felt that health equity was a 'buzzword' at senior levels but that FLS themselves "[didn't] have the resources to put [the buzzwords] into practice" (Participant 1033, FG 125-2, Phase 2). Comments about whether the health authority did or did not prioritize health equity were prevalent in both phases. The view of a disconnect between organizational talk and walk in relation to health equity was present in both phases but was more emphatic in Phase 2.

A few FLS discussed how organizational prioritization or lack thereof was influenced by higher level decision makers and by the public:

> Participant 187: [Prioritizing health equity is] hard, because it's not just like [the health authority]. This is, like, it's just so…
>
> Participant 182: Pharmacare, like…
>
> Participant unknown: Societal.
>
> Participant 187: Yeah. It needs to be so much integration. And it's like you said, policy. Like it's federal government, provincial government, and everything under that.
>
> Participant 188: Probably more under the *Canada Health Act* needs to be, you know, looked at and that kind of thing.
>
> Participant 183: And people in our community, making it a priority that everyone is equal in healthcare. You know, I don't think that the people that vote or go to town council meetings, that's not their priority. (FG 114-2, Phase 2)

This group of FLS saw prioritization as an outcome of complex social and political processes that went beyond the organization, a perspective that was present in both phases.

In most of the examples I have provided in this section, when FLS discussed whether the health authority prioritized health equity, the term 'health authority' most often implicitly meant 'senior decision makers in the health authority'. Occasionally this meaning came from the way interviewers phrased questions about organizational prioritization, for example, clarifying the question, "Would you say health equity is a priority… at the health authority level?" with, "Like [at] a senior level?" (Interviewer, FG 125-2, Phase 2). However, in most cases, FLS themselves substituted the meaning of 'health authority' with 'senior decision makers'. Rarely did FLS use the term ‘health authority’ to refer to the entirety of the organization or to themselves as part of that organization, but to a set of people above them in the hierarchy who determined the priorities and the distribution of resources available to FLS. However, this set of people was never personalized, in that specific people were never named, so it was unclear precisely who ‘senior decision makers’ referred to, whether directors of particular areas or executive leaders. Senior management and the health authority were always ‘they’, a depersonalized and non-specific set of people. This attribution was a key feature of the discourse of bottom level vs. higher ups.

Bottom level vs. higher ups

In the discourse of divergent priorities, FLS laid the blame for the constraints that prevented them from promoting health equity mostly on the shoulders of senior decision makers in the health authority. This blame was reinforced by the idea that there was a vast gulf between FLS and senior management. The five discourses I have presented so far discursively reinforced that distance between FLS and senior management in three additional ways: naming, in discussions of decision making, and through affective comparisons. These strategies produced the next organizational dynamic in this chapter, the discourse of bottom level vs. higher ups.

First, as many of the examples in this chapter have shown, FLS often referred to senior management as ‘higher ups’ or some variation of “they, the people up above, the echelons” (Participant 1028, FG 123-2, Phase 2). In contrast, FLS referred to themselves as ‘frontline’, ‘on the ground’ or sometimes ‘the bottom level’. This language established a distinction and distance between FLS and senior management and emphasized each’s position in the corporate organizational hierarchy. This language was consistent and did not change between phases.

Second, FLS argued that senior management often made decisions without understanding the realities of frontline work. This participant described wanting to be consulted on decisions that affected her work:

> When I say, you know, or any one of us says, 'We don't have enough staff, we're- we're all getting burned out, we have too much on our plate,' I want to be heard and something be done about it. Like I feel like we're the experts about what's happening on the frontlines and there's decisions being made way up at the top that don't know what we do on a daily basis. They don't engage us, they don't ask us questions, there's none of that. (Participant 138, FG 109, Phase 1)

This participant specifically juxtaposed the language "on the frontlines" with "way up at the top" to emphasize how distant senior management was from FLS's daily experiences.

A few FLS felt that senior management did consult with them on decisions and encouraged them (or at least did not interfere) when they proposed new programs or approaches to offering services. However, more were frustrated that "the conversations [with senior management] that have happened have been very token" (Participant 148, FG 110, Phase 1) or that FLS are asked for feedback "but it seems like it's to check off the box, it doesn't really determine what happens" (Participant 1000, FG 120-2, Phase 2). These comments echoed FLS's perspectives on the distance between 'talk' and 'walk' that was present in the discourse of divergent priorities.

FLS also said that organizational decisions and changes that impacted their work were not effectively communicated to them. When asked about barriers to applying health equity in their work, this FLS noted, "Getting communications, like all the way down, that's a barrier sometimes, we don't always get the information. Communication has definitely been a problem, that has been a barrier for a lot of years" (Participant 199, INTV 118-2, Phase 2). One team working in an area far north of the administrative hub of the health authority added this detail:

> Well the way [the health authority] works is decisions are made in [the administrative hub], and then the next person finds out, and then the next person finds out, and then the person above us tells us what to do, and we don't know why we're doing it, but you need to do it so you don't get in trouble up here. [laughter, agreement from others] (Participant 139, FG 109, Phase 1)

This FLS described how geographic distance exacerbated the separation between senior management and the frontline.

FLS perceived the distance between the 'bottom level' and 'higher ups' to be filled with layers of bureaucracy, which was a particular challenge when FLS or local managers were trying to advocate for changes to address gaps in services. One said:

> There are so many levels of management, and people that are completely disconnected from frontline nursing, that if you have even a good idea, like it takes like ages and ages to get things put through and they might not, because they have to go to [regional] meetings, and then they have to go to manager meetings and then they have to go higher than that, and then they come back to the manager meetings, and it just takes forever for change to be navigated through. (Participant 1004, FG 119-2, Phase 2)

The discourse of bottom level vs. higher ups was usually accompanied by a sense of frustration and hopelessness about bridging that distance.

There were some differences in these sentiments between Phases. Participants in both phases perceived that senior management did not understand the realities of frontline work and did not adequately communicate about changes. In Phase 1 a few FLS felt that 'higher ups' consulted with them and incorporated that feedback into relevant changes, but fewer felt this way in Phase 2.

The third way that FLS discursively produced a distance between themselves and senior management was through affective contrasts between local teams, mid-level managers and senior management. In Chapter 5 I described how FLS often talked about colleagues and local managers positively because they were committed to or worked towards health equity. I also noted that colleagues and local managers were described using ‘we’ and ‘our’. The common use of the words ‘our families’ also suggests that FLS identified clients as part of ‘us’.

In contrast, the vast majority of comments FLS made about senior management, either directly or by using the words ‘the health authority’ to mean senior management, were imbued with negative affect. For example, the criticism that senior management made decisions without understanding the realities of frontline work was deeply affective, as shown here:

> We are the ones who are building these relationships with these people and seeing the suffering and the hurt and the struggle that they go through, and we are the ones who feel so very powerless to help them. And then you have people up above us making these program changes that affect our families! And they’re not the ones who have to go and say, ‘Well sorry, we’re getting rid of [a universal perinatal program]’. [laughter, agreement from others] (Participant 187, FG 114-2, Phase 2)

In this chapter I have given numerous other examples of how this affective orientation was produced through FLS articulating criticism, frustration, demands and powerlessness in relation to organizational constraints on their ability to promote health equity.

These three discursive strategies – naming, discussing decision making, and affective comparisons – worked together to construct a specific organizational dynamic in which FLS and senior management were positioned at opposite poles of a hierarchical relationship characterized by divergent priorities and bureaucratic distance – the discourse of bottom level vs. higher ups. Local managers were located between the two groups but were associated closely with the frontline. As I will explore in more detail in the Discussion, this characterization of each group of actors in relation to each other and the organization produced a construction of each's commitment to and view of health equity.

Navigating constraints

I have described a number of ways in which FLS described how the organization they worked in constrained their ability to promote health equity in their practice. In response, FLS often described acting individually or as a team to navigate constraints so that they could promote health equity in the ways they felt were appropriate or ideal. These strategies constitute the discourse of navigating constraints, the last organizational dynamic I will present in this chapter.

Sometimes FLS described making intentional choices to disobey or skirt organizational guidelines and restrictions. When FLS perceived organizational restrictions to impede health equity or perpetuate health inequities, individuals or teams acted defiantly to block or reduce the impact of these constraints on themselves, clients and communities:

> Participant 125: With our birth control clinic, we have to put a cost on our birth control pills and contraceptives, but not everybody can pay. Plug your ears everybody, [quietly] I give a lot of birth control for free.
>
> Participant unknown: We have no names associated with that one. [laughter] (FG 108, Phase 1)

This is a typical example of how FLS intentionally, and usually with the support of their colleagues, subverted organizational rules.

FLS's ability to break or bend rules depended largely on how supportive local managers were. When managers were not supportive, FLS said they 'went underground'. Describing a situation in which a previous manager did not allow a team to use unoccupied work time to address local community needs, one FLS said, "Well so, we did it anyway, but never reported it anywhere, right? [others laugh] And that was the underground work is, we did so much stuff that we just didn't tell anybody we did" (Participant 1031, FG 125-2, Phase 2). Emphasizing the importance of managerial support, this same participant concluded, "Depending who's in the management, you do go underground more or less" (Participant 1031, FG 125-2, Phase 2). These comments echo what I reported in the previous chapter on micro relational factors on the importance of local manager support for the promotion of health equity.

In cases where resources were not available to offer the kinds of services FLS understood clients to need, FLS sometimes chose to work outside of their assigned responsibilities, either by taking up "little passions" "off the side of their desk" (Participant 159, FG 106, Phase 1) or by creating programs outside the health authority's purview. One FLS described these strategies:

> A lot of what you're hearing in terms of equity is being done by partnership, not necessarily by [health authority] funding. It's leveraging of the partnership, and that's part of what happens with [an early literacy program], that's part of what happens with a whole range of other programs that are done here. So, I just wanted to clarify how- how strongly this staff do- I mean, we talk about the [food bags], and that is also- a number of those bags are provided for free, some of them are low cost food, but again, that's not something- that's something that's initiated from inside this staff. (Participant 126, FG 108, Phase 1)

Most often, these "little passions" were carried out with the knowledge of local managers.

In response to the increasingly structured and prescribed nature of their work, and to the standardization of public health programs in particular, some FLS described being strategic about how their work was viewed within the organizational context. A few teams discussed their attempts to formally evaluate their programs and services in order to demonstrate that the health equity promoting work they were doing was of value, as this FLS describes:

> I think we feel a little nervous that nobody's actually seeing the work we're doing and really validating it from the top. And I think that accounts for maybe some of that crazy laughter that we had when you asked about [the extent to which] the health authority [prioritizes health equity]! Like I think that's us. And so we're feeling a little under the gun, but it's not a terrible thing. I think some of that's made us where we have a plan in place to talk about our framework for practice and to maybe talk about some measures because we're feeling like we need to be able to say how we're doing. (Participant 149, FG 110, Phase 1)

Again, FLS saw the work they were doing as valuable, perceived the organizational dynamics to be constraining their ability to do that work, and took action to open up organizational space for themselves, sometimes individually but more often as a team.

Regardless of how FLS negotiated the organizational constraints on how they promoted health equity in their work, both the constraints and the negotiations were laden with a richness of affect. Commonly, focus group discussions about navigating constraints were woven through with emotion: laughter and sarcasm at the low value the health authority put on health equity, frustration at restrictions on their activities, defiance or nervousness about subversion, embarrassment at breaking the rules, gratitude for being given autonomy and flexibility, passion for extra-system work, and sadness when FLS could not resolve these tensions in order to provide the care they believed clients needed.

For example, when FLS could not find effective ways to respond to organizational constraints, they discussed carrying the emotional weight of seeing the impact on clients and not being able to do more. One FLS noted:

> In the past, you would've, you wouldn't have worried about asking permission to [meet clients out in the community], you would've done it because that was what you saw as the need for that person. And there wouldn't be a sense of guilt because you would, you would have been meeting that client's need and so, you know, along with those restraints comes the emotional garbage and the baggage the nurse carries as well. And the fact that we can't do as much as we would like to do. (Participant 156, FG 106, Phase 1)

Descriptions of the ways in which FLS dealt with what they perceived as constraints on their ability to promote health equity in their practice produced the discourse of navigating constraints. FLS found themselves navigating or chose to navigate constraints in vastly different ways, some involving resistance and some involving acquiescence, but in all cases, they described a process of finding their way through the gaps between what they felt were ideal and appropriate ways to promote health equity and what they were able to do.

The discourse of navigating constraints reinforced the adversarial dynamics of the relationships between the practitioner and the organization that were the foundation of the discourse of divergent priorities and the discourse of bottom level vs. higher ups. In this adversarial articulation, FLS and their teams valued health equity but were often prevented from promoting it by the health authority not providing adequate resources, by limiting professional scope, by not prioritizing health equity or by prioritizing the wrong kind of health equity. The discourse of navigating constraints argued that it was the individual or team's responsibility to work to ensure that health equity was promoted *in spite of* the organization.

Chapter summary

In Chapters 5 and 6, I showed that many FLS understood a variety of factors in the organizational environment, in particular, interpersonal relationships, program resources and professional autonomy, to support them to promote health equity. However, FLS were more emphatic about how an organizationally produced context of scarce services, staff time, program resources and funding; bureaucratization and standardization; and the limiting of professional scope contributed to their sense that they had limited capacity to promote health equity. FLS said they were given time and resources for organizationally defined priorities such as immunization and other prescribed core public health tasks but were constrained in their ability to engage in activities that they saw as essential to promoting health equity but the organization saw as extra. This FLS summarized this constellation of constraints and the resultant impact on health equity:

> We see gaps and we see inequities but then we're also being- there's limits on autonomy and there's limits on job descriptions and there's limits on FTEs [full time equivalent positions] and like Participant 139 said as well, like you go in and you guys- we can only provide so much immunizations, don't know how much else we can do here because we don't always address all the social determinants of health like housing, like food security, like those kinds of things. It's like, 'Okay, here's your flu shot, good luck.' (Participant 140, FG 109, Phase 1)

The four organizational conditions of scarcity, bureaucratization, too much targeting and fighting to swim upstream worked together to produce a construction of the relationship between FLS and the organization they worked for. This construction involved three core organizational dynamics of divergent priorities, bottom level vs. higher ups and navigating constraints, which depicted the relationship between FLS and the organization as adversarial and distant, and in which the heath authority was seen as an antagonist to health equity practice at the frontline. This characterization was frustrating and troubling for FLS, as it contradicted their own deep commitments to the values and practices of health equity.

Chapter Seven: Discussion

My research question for this thesis was: *How do frontline public health staff engage with health equity during a time when the organization they work for has declared health equity an organizational priority?* In this chapter I outline the key observations of my research, link them to existing literature and draw out some of their implications for public health practice, for the concept of health equity and for future research on health equity in public health. I address each of my sub-questions in turn: first, *How do frontline public health staff understand and articulate the concept of health equity?* and then, *How do frontline public health staff articulate how relational and organizational factors impact their work on health equity?* Within each question I address relevant changes in my sub-questions over the period of study.

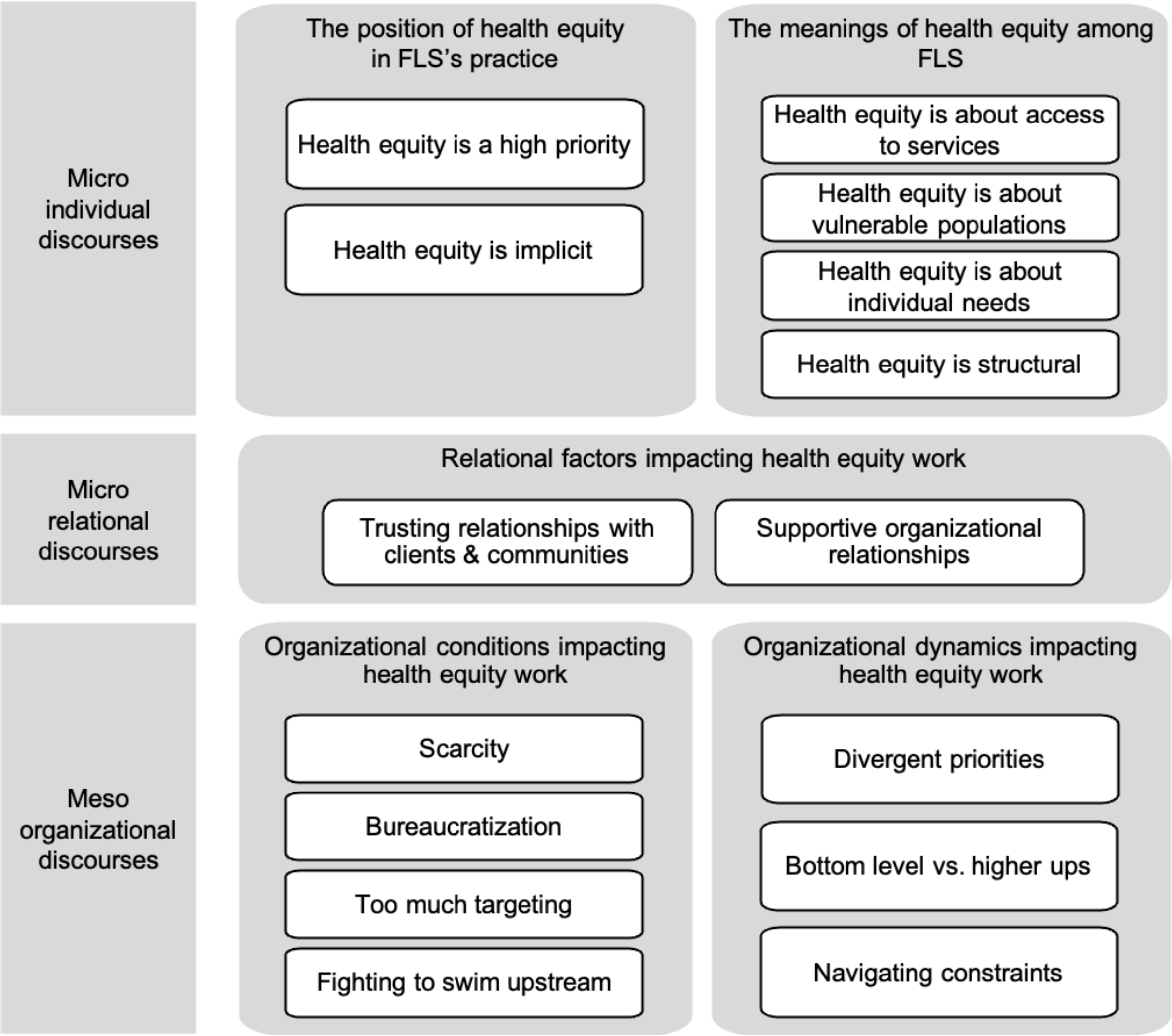
I used the following questions from Lawless and Chen's guide to critical thematic analysis to guide my reflection on my findings:

> How are everyday discourses enabled and constrained by social systems, dominant ideologies, and power relations? How do macro- and micro-level discourses, practices, and systems intersect and reproduce dominations and oppressions? How can individual subjects become aware of dominant ideologies and work toward challenging them and promoting social justices? (Lawless & Chen, 2019, p. 97)

By reflecting on these questions, I was able to connect the micro individual, micro relational and meso organizational discourses in circulation among FLS (see Figure 6) to each other and to wider structures of power. By examining the discourses in circulation among FLS in one health authority in BC, I was able to generate broad insights about how frontline public health providers (and other actors) might take effective action to promote health equity within the context of the Canadian public health organization.

Figure 6:

Discourses present in FLS's talk that articulate how they understand the concept of health equity and how relational and organizational factors impact their work on health equity



Understandings of health equity among frontline public health staff

A key theoretical premise of this thesis project was that epistemological positions shape possibilities for action (Fairclough, 2010; Talja, 1999). This means that the understandings of health equity that FLS engage in their work matter, particularly from the point of view of a critical theoretical orientation (Bowleg, 2017; Labonte et al., 2005). Different understandings of health equity enable different actions, each of which have a different capacity to substantively decrease health inequities.

FLS aligned themselves with a range of discourses related to health equity, and they felt that the basic premises of these discourses were central to their practice, even if they did not explicitly use the term ‘health equity’ to describe their practice. Almost all FLS were able to articulate their beliefs and positions on health equity and many were able to discuss the nuanced distinctions between different practice approaches associated with different discourses. The centrality of health equity to FLS’s practice reaffirms the importance of assessing which health equity discourses hold promise for a critical approach to inequities in public health.

In Chapter 4, I mapped out four discourses, or four epistemological positions, on the meaning and practice of health equity at work among FLS: 1) health equity is about access to services, 2) health equity is about vulnerable populations, 3) health equity is about individual needs and 4) health equity is structural. Most of these discourses can be found in the mainstream public health literature – with two important notes. First, FLS’s understandings of health equity skewed downstream to focus on service provision (discourses 1-3 listed above) instead of upstream to focus on structural determinants (discourse 4) or power and politics (almost absent in FLS’s talk). Second, the discourse of individual needs is not present in the public health literature on health equity, and is a concerning departure from some of the foundational ideas of the field. I discuss this latter point in more detail later in this chapter.

As I conducted my analysis, I found that the diversity of, and sometimes conflict between, articulations of health equity among FLS reflected key ethical and practice tensions in public health discussions about ideal action to promote health equity. In this section, I assess how each health equity discourse might enable or constrain critical action by mapping out how the discourses relate to three key tensions: upstream vs. downstream, equality vs. equity and individual vs. systemic. Examining current thinking on each tension will help me reflect on the potential positive impact of each of the four health equity discourses, and may provide guidance on how public health practitioners and leaders might navigate each discourse as they pursue health equity. I then compare the four health equity discourses to ideas about health equity present in BC public health policy documents in order to assess the alignment between public health policy and FLS's engagement with the idea of health equity, and to identify potential causes of any misalignment.

Upstream vs. downstream

The dominant perspective among FLS was that health equity should be pursued by ensuring that clients had fair access to services. Even when FLS understood poor health or other unmet needs to be produced by upstream structural phenomena such as the unequal distribution of the SDOH, their ideal solutions generally remained within the downstream realm of service access. The less common perspective was that health equity was best achieved through structural endeavours like community development or public policy advocacy.

My findings echo many other studies of public health and health care practitioners that have found that ideal health equity action is most often understood as ensuring individual or group access to health promoting resources (downstream factors) and less often as addressing structural issues related to policy and politics (upstream factors) (Brassolotto et al., 2014; Hassen et al., 2017; McMahon, 2022; Pauly et al., 2017). The discourse of health equity as access to services is present in Whitehead's early articulations of equity in health care, and FLS's comments about the need for public health services to be available, accessible and appropriate echo Whitehead's (1991) emphasis on accessibility, quality and acceptability of care. This discourse also mirrors understandings of health equity that naturalize health inequities (e.g., Braveman et al., 2011; Whitehead & Dahlgren, 2006) because the discourse does not draw attention to the structural root causes of health inequities (Plamondon et al., 2020).

The discourse of health equity as structural mirrors elements contained in the Ottawa Charter for Health Promotion – namely, strengthening community action and building healthy public policy (World Health Organization, 1986). It is crucial to distinguish, however, between upstream action to improve the SDOH for individuals and communities and further upstream action to shift political and economic structures that produce inequitable distributions of power and resources (Raphael, 2011). FLS's sense of health equity as structural did not include the latter kind of upstream action. Therefore, no discourses in circulation among FLS problematized health inequities by naming their root causes and directing action at those roots (Plamondon et al., 2020).

The dominance of the discourse of health equity as access to services is understandable given the professional scope of the FLS who participated in the study. Most were public health nurses and the rest were allied professionals or paraprofessionals; by definition, the primary scope of frontline service providers is to engage in one-on-one service delivery. Only a few FLS's professional scope explicitly allowed them to work on structural issues, although others wanted to but were fighting to swim upstream due to a perceived lack of value and support from their organization for structural level work.

The tensions between upstream and downstream discourses reflect a persistent predicament in health equity work. Many years of public health policy, practice and research has concluded that upstream action on the distribution of the SDOH and even further upstream, on socioeconomic systems and the distribution of power and resources that produce those systems, has a greater impact on health inequities than downstream activities that take place in one-on-one service provision (Braveman & Gottlieb, 2014; Navarro, 2009; Scott-Samuel & Smith, 2015). However, like the participants in this study, the majority of the public health workforce in Canada continues to have a professional scope that focuses on the latter (National Collaborating Centre for Determinants of Health, 2015; Public Health Agency of Canada, 2008). The FLS in this study are not alone, as many other public health and acute care practitioners are also struggling to swim upstream, to shift the locus of thinking and action away from downstream factors (Kiran & Pinto, 2016; McPherson et al., 2016; Whitehead & Popay, 2010).

Despite the dominance of downstream discourses, no FLS in this study argued that upstream approaches were inappropriate or undesirable ways to work towards health equity. In fact, changes between Phase 1 and Phase 2, which saw more FLS talking about how poor SDOH impacted their clients, describing their structural level work and naming constraints to working upstream, suggest that the structural discourse may have been gaining ground, as FLS's understandings of health equity shifted upstream slightly over the data collection period.

Over that same time period, however, FLS may have faced increased organizational constraints to thinking and acting upstream, even beyond the organizational conditions they described. A separate arm of the ELPH study, which compared the health equity lens of senior leaders in a health authority in BC at approximately the same two time points as my study, found that leaders' understandings of health equity narrowed over time. In 2013/2014, leaders saw health equity as valuable but were uncertain about what action to take to promote it; their diffuse understanding of health equity included ensuring access to services and some mention of the SDOH. However, in 2015/2016, leaders' health equity lens had narrowed to a focus on targeting 'vulnerable' populations for equitable access to services (Pauly et al., 2017). Therefore, at the same time that FLS in my study were widening their understandings of health equity to include more mention of structural factors, leaders' understandings were narrowing to exclude this perspective, potentially creating even more organizational constraints and a bigger chasm between the bottom level and the higher ups.

Equality vs. equity

Some FLS were deeply committed to equality of service access while others championed equity. The ideas of equality and equity of access as described by FLS align with concepts of horizontal equity (equal resources for equal levels of need) and vertical equity (different resources for different levels of need) present in early definitions of health equity.

For FLS, equity most often meant that those who needed more got more, not that people who needed less got less. This idea echoed Whitehead and Dahlgren's (2006) principle that the path to equity involves levelling everyone in a society up to the health status of the most advantaged, not levelling down, although FLS were focused on services and Whitehead and Dahlgren on health outcomes. Although most FLS saw the value of vertical equity, some explicitly pushed back against it via the discourse of individual needs, arguing that the organizational implementation of programs informed by vertical equity pushed horizontal equity below an acceptable threshold.

The distinction between equality and equity was a key part of early ethical formulations of health equity (e.g., Braveman & Gruskin, 2003; Pan-American Health Organization, 2001) and although this conceptual difference is less often highlighted in recent scholarship, it continues to be present (e.g., National Collaborating Centre for Determinants of Health, 2020b). Critical public health research has generally accepted the importance of equity-based approaches to the redistributive allocation of health promoting resources, as providing equal levels of service to all has been found to maintain and even exacerbate health inequities (Carey et al., 2015; Pan-American Health Organization, 2001). Others have argued that philosophically robust conceptions of equality, which specify what kinds of inequalities are unjust and how and under what circumstances they ought to be redressed, still hold value for public health practice (Smith, 2015). Nevertheless, both equality and equity continue to be bound up in ideal formulations of justice and fairness among public health leaders and practitioners, who often do not make the distinction between equality and equity (Pauly et al., 2017; Rizzi, 2014). Some public health thinkers have argued that practitioners should openly discuss the difference between equality and equity in order to highlight the moral underpinnings of each and equity's unique potential to emphasize the redistribution of power and resources (Oickle & Clement, 2019).

Many FLS saw equality and equity as complementary through the framework of universal and targeted services, echoing other research that has found that public health practitioners see the value of both approaches (Aston et al., 2014). FLS mostly understood targeted approaches as focusing on clients with the poorest health and social determinants (targeted universalism) instead of distributing public health services and social determinants across the social gradient (proportionate universalism) (Marmot, 2010; National Collaborating Centre for Determinants of Health, 2013b). Scholarly critiques of targeted universalism echo FLS's assertions that some clients were 'falling through the cracks', arguing that simply adding targeted programming onto a minimal base of universal services ignores the reality of the health gradient and therefore tends to leave out people who have greater need than average but not enough need to make them eligible for targeted programs (Carey et al., 2015; McLaren, 2019).

Individual vs. systemic

FLS had different perspectives on the appropriateness of allocating services and other resources to clients on a case-by-case basis or by social category, that is, whether the distribution of resources should take an individual or systemic approach. Some FLS believed that discourses based on social categories, such as the discourse of health equity being about vulnerable populations, reproduced inequities and imperiled client-centered care by erasing client individuality and harming relationships. However, most FLS believed that social categories were helpful to understand the causes of health inequities and determine how to target services based on the concept of vertical equity.

Critical public health literature has by and large accepted that paying attention to inequities produced by structures of domination that treat members of different social groups differently is essential for remedying those inequities. Indeed, I framed this thesis project by citing key public health thinkers who explicitly defined health inequities as differences in health that align with differences in social condition or position (Braveman, 2014; Marmot et al., 2008; Pan-American Health Organization, 2019; Whitehead & Dahlgren, 2006). However, some literature has argued that discourses that rely on a systemic analysis such as the discourse of vulnerable populations can become pernicious when combined with epidemiological analysis and organizational bureaucratization to produce the practice of ‘labeling’ people with poorer health, which can be reductionist and stigmatizing (McMahon, 2022). Others have challenged an over-reliance on social categories or a population approach for erasing human individuality and the inherently relational experience of the client-provider relationship (Falk-Rafael, 2005; Peñaranda, 2015). These critiques are valuable and can be used to refine how a social group analysis is applied to health equity, for example, by ensuring that bureaucratic assessments and interventions leave room for the complexity of human individuality and relational practice. However, I would argue that critiques of the implementation of a systemic analysis in practice do not inherently challenge the value of a systemic approach. However, proponents of the discourse of individual needs would disagree.

A discourse in resistance

Although I have described various critiques of the application of vertical equity and a systemic analysis, outright resistance to these ideas among FLS has not yet been documented in public health literature as a coherent discourse. The one exception is Falk-Rafael and Betker's (2012a) study of public health nurses, which found that participants had trouble maintaining relationships with clients when their work shifted to more population-based interventions. Nurses felt that relationships were essential to help them understand community needs and establish the trust needed to deliver programs and services, but spending time on structural interventions meant that nurses had less time for direct contact with people. However, these participants did not feel that they *ought not* to work at a population level, only that it presented challenges to their one-on-one work. Therefore, the identification of the discourse of individual needs is a key contribution of this study.

This discourse is a concerning epistemological position on ideal action to promote health equity. The discourse of individual needs explicitly rejected the logics of vertical equity and a systemic analysis in favour of equality of access, individuality and client-centered care. Although the discourse did not reject working upstream outright, it focused on downstream service provision.

From a critical perspective, the discourse of individual needs is disturbing for those working to promote health equity in public health systems. First, taking a group analysis out of the discursive framing of health inequities risks erasing how social categories materially impact people's health. If health equity, as critical public health scholars have affirmed and as I have defined it in this thesis, requires attention to differences in social condition or position, then the discourse of individual needs discards foundational elements of health equity. Removing a systemic analysis eliminates information that is useful for practitioners to ensure equitable access to services (Pauly et al., 2009). The erasure of social categories also risks holding people individually responsible for circumstances produced by structural relations of domination (Varcoe et al., 2014), an aspect of the ‘lifestyle drift’ that has been heavily critiqued in public health literature (Baum, 2011). Therefore, the discourse of individual needs risks working against the promotion of health equity.

Second, the discourse of individual needs remobilizes language like ‘marginalized’, which was initially intended to describe systemic relations of power, and empties it of a systemic analysis, thereby depoliticizing that language. This discursive move potentially depoliticizes the concept of health equity itself, hollowing it out to an individualist matter of ‘fairness’. This is worrisome, especially at a time when many public health scholars are calling for more, not less, politics in public health (Heller et al., 2024; Iton & Shrimali, 2016). I will discuss the implications of depoliticizing health equity in more detail later in this chapter.

The perception among some FLS that there was an imbalance between universal and targeted approaches might account for the prevalence of the discourse of individual needs. The discourse of individual needs may have been a way for FLS to resist the ascendance of heavily bureaucratized targeted programs that left them with little time and resources for universal programs. In response, FLS reaffirmed their commitment to ideas of equality of access, individuality and client-centered care, arguing that equity, as it was being implemented in their organizational context as highly structured targeted programs, was endangering these values and practices.

However, I would argue that equity and a systemic analysis do not inherently undermine a universal approach to public health services or client-centered care, but that resource scarcity and bureaucratization, key organizational discourses present during both phases of this study, might. The discourse of scarcity posited that there were not enough resources to promote health equity with clients. The discourse of bureaucratization described how FLS were subject to increasingly rigid roles and a prescribed approach to health equity, which took away the time, resources and professional autonomy that they would otherwise have used to do relationship building and provide both universal and targeted services. Within the organizational context and time period of my study, new perinatal programs informed by ideas of equity and vulnerable populations happened alongside (and sometimes produced) resource scarcity and increased bureaucracy. In this way, the discourse of individual needs, while grounded in a conceptual rejection of equity and a systemic analysis, may also have been a way to resist these organizational constraints.

As I will discuss below, counter-discourses such as the discourse of individual needs can be a generative force for change when they resist relations of domination in organizations. However, the discourse of individual needs, particularly as it was articulated via the discourse of too much targeting, risked denigrating a systemic approach to health equity instead of critiquing organizational conditions of scarcity and bureaucratization, thereby aligning with and supporting larger sociopolitical trends of neoliberal individualism, which have been identified as a significant threat to health equity action (Baum, 2011; Labonté & Stuckler, 2016; Pauly et al., 2009).

Alignment of discourses with BC public health policy

I noted in Chapter 6 that in the focus groups with FLS, there was only one explicit mention of the 2005 *BC Core Functions Framework for Public Health* (Ministry of Health Services, 2005a), the foundational document that articulated the need for a health equity approach in all public health programs in BC. However, in this section, I argue that the discourses in FLS's talk implicitly mirrored the concepts present in the Inequalities Lens (later called the Equity Lens) of the Core Functions Framework. The description of the Inequalities Lens noted that public health should aim to reduce inequalities in health through community development and public policy advocacy and by directing more attention to people who are in greatest need of public health services (Ministry of Health Services, 2005a). All three of these approaches were present in FLS's talk about health equity, although community development and public policy advocacy were deemphasized in favour of one-on-one service provision.

Many of FLS's understandings of health equity also reflected the 2005 Core Functions Framework's Populations Lens, which suggested that "while some core programs should be universal (e.g. immunization, inspection of water and food, etc.), others should be preferentially or exclusively provided to selected populations that are at higher risk or are more vulnerable due to biological, social, environmental, economic, cultural, or other factors" (Ministry of Health Services, 2005a, p. 49). A combination of universal and targeted programs recommended in the Core Functions document as well as the specific language of 'high risk' and 'vulnerable' used in the Inequalities and Populations Lenses were present in FLS's talk.

The 2013 (revised in 2017) *BC Guiding Framework for Public Health* (Province of British Columbia & Ministry of Health, 2013) also contained sections on public health's role in health equity and population health. The health equity section in this document made less explicit mention of community development and public policy advocacy as key elements of health equity promotion and focused more on universal and targeted service provision. The population health section took a more upstream approach, describing the importance of public policy and intersectoral action to impact the determinants of health. Therefore, FLS's talk also echoed some of the ideas found in the Guiding Framework for Public Health.

Pinto et al.'s (2012) analysis of the Core Functions Framework and the 15 associated Model Core Program Papers (evidence reviews created to support each of the 21 program areas contained in the Core Functions Framework) found that collectively, the documents outlined five types of actions that public health should take to reduce health inequities. They included: quantifying inequities, taking action on the SDOH via policy and community development, public policy advocacy, intersectoral collaboration, and ensuring access to services, which included universal and targeted programs. FLS in my study mentioned working on or wanting to work on all five types of actions, although the last action – ensuring access to services – was the most commonly discussed. All of this suggests that despite FLS in this study almost never mentioning the Core Functions Framework or the Guiding Framework for Public Health, their understandings of health equity mirrored much of the content of BC public health policy documents during the 2005-2017 period. The one exception was the discourse of individual needs, which was not present in either of these policy documents.

Where FLS's understandings of health equity departed from those articulated by BC public health policy documents, the reasons for the departures may have in part been produced by the organization FLS worked for. The downstream skew of FLS's understandings of health equity may have been due to their restricted scope of practice and bureaucratized programs that took time and organizational support away from structural level action. The discourse of individual needs was in large part a response to the simultaneous erosion of universal services and professional autonomy. Therefore, although BC policy documents envisioned a public health practice explicitly guided by ideas and practices of health equity, according to FLS, the public health organization tasked with operationalizing that policy was a key obstacle to its implementation.

Relational and organizational factors impacting health equity work among frontline staff

In this chapter I have already given some examples of the ways in which the relational and organizational discourses I found in FLS's talk impacted how they engaged with the idea of health equity – for example, how FLS's emphasis on downstream actions to promote health equity was understandable given the organizational constraints that prevented them from working upstream. In this section I delve deeper into the implications of these relational and organizational discourses for health equity action. I first show how many of these discourses are present in the public health literature and look at their impacts in other contexts. I then introduce two organizational theories that might help us understand the organizational dynamics at play in the health authority under study – the discourse of bottom level vs. higher up and the discourse of navigating constraints. I do this in order to comment from a critical theoretical perspective on the potential of these discourses to challenge or reproduce inequitable relations of power and domination and thereby health inequities.

Divergent priorities

Although FLS saw some organizational factors as supporting them to promote health equity, most believed that the organization was impeding their efforts and that therefore, FLS's values and priorities were different than those of the health authority they worked for. Many of the organizational conditions that FLS identified as enabling or constraining their work on health equity are present in other literature on health equity work in health systems.

Trusting relationships. All FLS placed a high value on relationships and trust and understood them as essential to promoting health equity. Trusting relationships underpin two of the five health promotion strategies articulated in the Ottawa Charter for Health Promotion – developing personal skills and strengthening community action – and so can be understood as foundational to public health practice (Falk-Rafael, 2005; World Health Organization, 1986).

An emphasis on relationships and trust is also present in scholarship on critical, feminist and emancipatory nursing in public health and beyond. Various frameworks for nursing oriented towards social justice and equity have highlighted the ways in which nurses can work interpersonally to affirm the humanity of all clients, share power, engage with multiple ways of knowing and attend to clients' SDOH through their practice (Cusack et al., 2017; Falk-Rafael & Betker, 2012b; Varcoe et al., 2014).

Scarcity. The discourse of scarcity described how insufficient time and resources were allocated to health equity action and to public health more generally. FLS felt that, in part due to scarcity, activities such as outreach and relationship building which were crucial to the promotion of health equity were seen by the organization as extra, not as core elements of public health service provision. FLS's claims are corroborated by Dahl's (2018) study of public health nurses in Norway, which found that limited time and resources resulted in providers prioritizing individual level problem solving instead of population level work and Kirk's (2020) study, which described how public health renewal in BC contributed to an increase in public health nurse workload and a decrease in available program resources, undermining (among other things) their ability to promote health equity.

FLS's claims in this study that public health was undervalued and underfunded compared to acute care reflect ongoing assertions from critical scholars that public health in Canada is under siege (Guyon et al., 2017; Potvin, 2014) as well as calls for governments to increase investments in prevention and the upstream causes of health inequities. These critiques link underfunding to medicalization, neoliberal austerity and policy maker resistance to bolstering welfare state provisions (Hemenway, 2010; Labonté & Stuckler, 2016; Masters et al., 2017; Raphael, 2015).

Bureaucratization. The discourse of bureaucratization articulated how recent shifts towards the standardization of public health work encroached on FLS's capacity to use their professional skills and discretion to make autonomous decisions about their practice. Instead, prescribed tasks, rigid directives and increased oversight from managers as well as pressure to quantify the impacts of their work constrained FLS's ability to flexibly address the needs of clients, especially if these clients did not fall into program-delineated categories that entitled them to services. Bureaucratization also made FLS feel that the organization did not trust or value them as professionals.

The bureaucratization of public health practice through the mandated use of checklists and restrictive assessment tools has been observed in other Canadian studies of public health practitioners, which have suggested that the introduction of standardizing systems and processes can interfere with FLS's ability to provide care in a way that promotes health equity (Kirk, 2020; Marcellus et al., 2022). Work from the UK has argued that a focus on targets and outcomes as part of the bureaucratization process also harms health equity work (Orton et al., 2011).

In a study of Canadian acute care nurses, Choiniere (2011) describes the managed care approach to accountability on the rise in public sector health organizations in Canada in the late 1990s. Based on "neoliberal assumptions that the public sector in general and health care in particular are inefficient and wasteful drains on the state" (Choiniere, 2011, p. 330), 'accountability' narrowly translated to 'efficiency' and 'cost saving'. Managed care imported features from the private sector into health systems, leading to the corporatization of nursing practice. Choiniere describes features typical of an accountability approach to health care reform, such as standardized care pathways and charting, a focus on evidence-based practice and measuring the (quantifiable) outcomes of care, and the administrative shift of services from profession-based departments to program-based structures. These features resulted in nurses experiencing a decline in their professional autonomy, a task orientation to their work, and greater administrative oversight and intervention into their practice, with ultimate negative impacts on nurse wellbeing and the quality of patient care. The similarities between the perspectives of the FLS in my study and other studies of public health practitioners and Choiniere's work are striking, suggesting that such corporatizing organizational moves towards accountability have made their way into public health systems. Given the consensus among frontline practitioners in the literature that these moves negatively impact patient care (including health equity) and practitioner wellbeing, this approach to public administration of health systems may need to be curbed if FLS are to effectively promote health equity.

The standardization of public health services was one of the main goals of BC's Core Functions Framework (first released in 2005), which aimed to outline clearly defined functions for the public health system as well as the minimum bundle of public health services that all health authorities should provide (Ministry of Health Services, 2005b). However, it was not clear whether the rise in standardization and mandated programs described by FLS (in 2014-2015) was a result of the implementation of the Core Functions Framework, as only one participant explicitly made the link between this framework and what she saw as positive changes to public health practice. Nevertheless, the negative effects of bureaucratized practice on FLS's experiences of their work and their ability to promote health equity suggest that standardizing initiatives should be approached carefully, with close attention to their impacts on the frontline.

Too much targeting. The discourse of too much targeting posited that there was an ideal combination of universal and targeted approaches to public health services, although there was a diversity of opinion among FLS as to what exactly the appropriate balance looked like. The main concern among many FLS was that the increase in targeted services informed by concepts of vertical equity was eroding universal services informed by concepts of horizontal equity, due to a shift in organizational emphasis under a climate of overall resource scarcity.

The tension between universal and targeted approaches to public health has been under debate since the 1980s (Rose, 1985; Skocpol, 1991) and the last 40 years have seen a number of writers attempt to articulate the right balance between the two. For the most part, scholars advocate for a combination of the two approaches, arguing that implementing only universal or only targeted policies and programs will have negative effects on population health and health equity (Carey et al., 2015; Marmot, 2010; National Collaborating Centre for Determinants of Health, 2013b). However, some researchers have critiqued recent shifts towards targeted and away from universal approaches, both in policy and programs. These authors draw on the gradient model of population health articulated by Rose (1985) to argue that a universal approach remains beneficial for health equity: universal approaches often have the most benefits for the worst off, catch clients who do not seek out services and are less prone to the challenges produced by targeted approaches such as inaccurate screening and service cutoffs (Elkan et al., 2001; McLaren, 2019).

Concerns about the erosion of universal approaches can be found in other empirical work with public health practitioners. Research with frontline staff in BC, Nova Scotia and Ontario has discovered that an increased emphasis on targeted programs has resulted in a decrease in and devaluing of universal programs below what practitioners felt was an acceptable threshold (Aston et al., 2014; Kirk, 2020) or simply in uncertainty about how to deliver the right balance of universal and targeted programs (Rizzi, 2014). Given these trends, it seems that the FLS in my study who perceived that the balance had tipped too far in the direction of targeted programs, producing a resultant negative impact on health equity, were not alone in their concerns.

Fighting to swim upstream. Limited autonomy as well as a restricted professional scope meant that some FLS had to fight to swim upstream as they attempted to work on the structural causes of health inequities through community development and public policy advocacy. Some FLS identified that they were not permitted to do this work and others faced challenges when they attempted to.

This constraint on FLS's ability to work on health equity at structural levels is widely documented in empirical studies of public health practice. A number of studies have found that public health practitioners do not see structural factors as part of their scope (Brassolotto et al., 2014; McPherson et al., 2016) or are told explicitly by managers that it is out of their scope (Cohen & Marshall, 2017; Rizzi, 2014).

When they do find it within their scope, they face other barriers to working structurally. Such barriers include a lack of time, capacity and interdisciplinary relationships as well as public health organizations' lack of independence from the governments that policy work would require them to critique (Cohen & Marshall, 2017; Cusack et al., 2017; Dahl, 2018; McIntyre et al., 2013). Given the research that argues that substantively decreasing health inequities requires actors to work upstream, these conditions make it difficult for practitioners to carry out the essential role of public health as an advocate for policy that promotes health equity.

The relational and organizational discourses of trusting relationships, scarcity, bureaucratization, too much targeting and fighting to swim upstream worked together to produce the discourse of divergent priorities, which represented idea that the health authority was an antagonist of frontline health equity work.

Bottom level vs. higher ups

Through the discourse of divergent priorities, FLS described themselves to be deeply invested in and intimately connected to the everyday practice of health equity. FLS mostly said that distant and out-of-touch senior leaders and the bureaucracy that they produced and represented impeded health equity or promoted forms of health equity that were rigid, prescribed and inappropriate.

The discourse of bottom level vs. higher ups was the second key organizational dynamic through which FLS described their relationship with the organization and how the organization impacted their health equity work. The discourse of divergent priorities and the discourse of navigating constraints were both refracted through the prism of bottom level vs. higher ups.

The discourse of bottom level vs. higher ups described a distance between the frontline and senior leaders. FLS disidentified themselves from senior leaders and identified senior leaders with the organization. When discussing the constraints they faced in their health equity work, FLS used the language of ‘the health authority’ and ‘higher ups’ interchangeably, suggesting that they saw senior leaders as emblematic of the organization. Instead, FLS identified with their own local teams and managers. This suggests that FLS did not view themselves and their teams as ‘the organization’ but as practitioners working within an organization governed by a distant senior leaders. Therefore, FLS understood their health equity work to be taking place within the context of an organization that was a distant, disconnected and unsympathetic antagonist of that work.

Leader distance

Organizational research has long studied the relationships between leaders and followers (leaders' subordinates). The concept of leader distance, first articulated by Napier and Ferris (1993), describes how the distance between leaders and followers is produced and perceived and how it impacts the experiences of both groups and, ultimately, the performance of the organization. The basic premise of leader distance is that in hierarchical organizations, separations between leaders and followers produce a psychological experience of distance (Shamir, 2012). The experience of distance can be widened by physical or geographical distance (e.g. different office locations), social distance (e.g. different social status or groups) or a lack of interaction (Antonakis & Atwater, 2002; Shamir, 2012).

Organizational theorists have argued that humans tend to seek out social identification, the "perception of oneness with or belongingness to some human aggregate" (Ashforth & Mael, 1989, p. 21). Researchers have found that the more closely a follower's identity is linked to that of the leader and the organization, the more likely they are to perceive the actions of leaders and the organization positively (Treviño, 2021). Generally, low level employees tend to identify with their work group instead of with the organization (Treviño, 2021). Lower level employees have also been found to have a more negative perception of the ethics of the organization (Treviño, 2021) and less commitment to organizational change (Hill et al., 2012). In contrast, those at higher levels of the organization tend to identify with the organization and view the ethics of the organization positively (Treviño, 2021).

Leader distance has implications for how followers identify with leaders and consequently with the organization. Leader distance impacts identification in part via trust: when leaders are distant, direct observations of leader behaviour are less possible, so followers use their attributions of the leader to judge whether they are trustworthy, which often rely on followers' sense of whether the leader's values align with their own (Shamir, 1995). When a leader represents the values of followers, followers are more likely to identify with that leader and thereby with the collective that that leader leads (Antonakis & Atwater, 2002). The social distance produced by being 'at the top' also decreases a leader's ability to understand and empathize with the individual interests of those at lower levels (C. Anderson & Brion, 2014; Magee & Galinsky, 2008).

Thus, the discourse of bottom level vs. higher ups aligns with theories of leader distance proposed in the organizational theory literature, specifically, that identification with and trust of the leader and the organization are bolstered by followers' perceptions that the values of leaders reflect their own, and that employees at lower levels and employees who disidentify with the organization tend to see leaders and the organization more negatively. This theory may also in part explain FLS's assertions that leaders did not consult with them on key decisions related to health equity and public health practice despite the impacts of these decisions being experienced by FLS and their clients, because leader distance prevented leaders from empathizing with the interests of followers.

As the ELPH study team was designing the data collection strategy (Pauly et al., 2013), senior leaders in the health authority suggested that the researchers did not need to conduct interviews with frontline staff about health equity because staff would have no understanding of the concept. However, given that FLS were the ones responsible for the implementation of top-down policy initiatives in the health authority such as the Core Functions Framework Inequalities Lens, the study team decided to interview them. It is clear from the findings of my study that FLS had rich and nuanced understandings of health equity, although they did not often use that language, and although their conceptions of health equity were different from those of senior leaders discovered in another arm of the ELPH study (Pauly et al., 2017). Indeed, a number of FLS expressed to the researchers that they were grateful to talk about health equity (B. Pauly, personal communication, February 6, 2020). The difference between senior leaders' perceptions of FLS and FLS's perceptions of themselves echoes the discourse of bottom level vs. higher ups in circulation among FLS as well as theories of leader distance.

Navigating constraints

Another insight into the organizational dynamics governing health equity work comes from the discourse of navigating constraints. Organizational constraints on health equity action generated ethical tensions for FLS that they then needed to resolve. Many FLS took actions that they felt were appropriate and ethical but were not in line with organizational directions. This included disobeying prescriptions and restrictions, 'going underground' by not reporting on actions they took, going beyond assigned responsibilities or attempting to justify the work they wanted to do. The navigation of organizational constraints was laden with emotions like frustration, worry, excitement, sadness and appreciation.

Kirk's (2020) research described a very similar set of constraints that, the author argued, "eroded the nature of the public health nurse role and negatively influenced public health nursing practice, undermining the ability of public health nurses to improve population health and health equity" (Kirk, 2020, p. iii). The nurses in Kirk's study used strategies for responding to constraints that were similar to those FLS in my study described: getting by (working within constraints, including finding creative solutions), standing tall (advocating for their practice, including resisting unwanted change, proposing new programs to address service gaps and demonstrating impact), going underground (subverting organizational barriers by acting without permission, going beyond roles and relying on community partners), contemplating getting out (considering leaving the job) and reaffirming commitment (restoring their dedication to their role, which included finding meaning in the work). McPherson et al. (2016) reported that public health nurses working on the SDOH also used some of these strategies, including targeting leaders resistant to change, strategically creating partnerships and embedding health equity positions in the organization.

Marcellus et al. (2022) found that public health practitioners used workarounds to circumvent system constraints in health equity work; the authors characterized workarounds as a strategy for navigating ethically challenging situations. Other scholars have also applied an ethical lens to the question of how FLS in public health navigate organizational constraints. Pauly et al. (2021) described the moral distress generated by public health practitioners seeing through a health equity lens what their clients needed but not being able to offer those things. Marcellus et al. (2022) also used the concept of moral distress to demonstrate that when public health practitioners enacted commitments to health equity, they were not following the organization’s direction but their own moral principles. Both studies found that practitioners responded emotionally to situations of moral distress, either with self-oriented emotions such as discomfort or sadness or with emotions directed at the organization such as fear (Marcellus et al., 2022; Pauly et al., 2021). Therefore, the strategies for navigating constraints used by the FLS in my study are common to other public health practitioners working on health equity, as are the emotional aspects of this navigation. In addition, an ethical lens may be a useful way to understand how practitioners navigate organizational constraints on their ability to promote health equity, which is an inherently ethical concept.

Organizational resistance

I understand the actions of FLS described in the discourse of navigating constraints as forms of organizational resistance, in that they challenged practices and processes of public health work prescribed by those above them in the organizational hierarchy. Organizational theory has examined the ways in which low-level employees resist organizational constraints. One such concept that might be relevant for understanding FLS's experiences, in part because it contains an ethical component, is organizational cynicism, which is defined as a "negative attitude toward one's employing organization" (Dean et al., 1998, p. 345). Applying organizational cynicism to my findings builds on existing research describing the ethical tensions, change fatigue and mistrust of organizational change initiatives experienced by public health and other health care practitioners (Erasmus et al., 2017; Marcellus et al., 2022; Pauly et al., 2021; Tomm-Bonde et al., 2013).

Organizational scholars have proposed a conceptualization of organizational cynicism comprised of "three dimensions: (1) a belief that the organization lacks integrity; (2) negative affect toward the organization; and (3) tendencies to disparaging and critical behaviors toward the organization that are consistent with these beliefs and affect" (Dean et al., 1998, p. 345). FLS's assertions that the organizational constraints impeding health equity were inappropriate and unfair and that senior leaders 'talked the talk but did not walk the walk' suggested a belief that the organization lacked integrity. Negative affect was clear in FLS's feelings of anger, contempt, distress and moral superiority in relation to senior leaders and the organization as a whole, as was behaviour associated with cynicism such as criticism, sarcasm, sneers and frustrated and pessimistic talk (Dean et al., 1998).

Cynicism is closely associated with disidentification, in that employees who identify with the organization are more likely to share its vision and goals and therefore less likely to be cynical (Rho et al., 2021). Given that low-level employees are generally more likely than high-level leaders to view the organization negatively and disidentify with it (Hill et al., 2012), it is not surprising that organizational cynicism has been found to be higher at the bottom of the hierarchy than at the top (Treviño, 2021). All of these aspects of organizational cynicism echo my findings. In addition, followers who are more distant from leaders are more likely to be cynical about organizational change initiatives and lack faith in those responsible for change (Hill et al., 2012), which has implications for formal health equity initiatives created by senior leaders. In my study, FLS's resistance to top-down health equity initiatives may have had as much to do with the their position in the hierarchical structure of the public health organization as with the content of those initiatives.

Cynicism is understood by some critical organizational scholars as a productive act of everyday organizational resistance that "crafts emancipatory space within relations of domination" (Fleming, 2005, p. 55). Cynicism can be a defence of selfhood against the domination of the organization that allows the worker to, among other things, "protect their authentic values when the schism between lived experience and [organizational] rhetoric is too stark" (Fleming, 2005, p. 50). Disidentification, which was a key element of the discourse of bottom level vs. higher ups, can also be understood as a form of subtle resistance, in which employees distance themselves from the organization's values and goals (Fleming & Spicer, 2003). In this way, the disidentified and cynical orientations of FLS might be understood as an attempt to navigate not only organizational constraints but their own sense of self, identity and moral commitments to clients, communities and health equity.

However, organizational scholars disagree about the potential of cynicism and disidentification to produce disruptions to material relations of domination in the workplace.

Cynicism and disidentification can act as a safety valve, allowing workers to let off steam and gain some sense that they are autonomous actors who can keep their distance from management's prescriptions, even as they, for the most part, still perform their roles according to those rules (Fleming & Spicer, 2002). On the other hand, psychological forms of resistance like cynicism and disidentification can support workers to materially challenge unethical organizational behaviour. For example, Fleming and Spicer emphasize the worker agency present in cynicism when they assert, "we understand cynicism to be situations where people look for the 'naked truth' behind the official 'party line' so that blatant contradictions are laid bear [sic]" (Fleming & Spicer, 2002, p. 71). Cynicism can allow workers to develop discourses that challenge official organizational narratives and shape workers' sense of themselves, which can provide discursive fuel for more material forms of worker organizing and resistance (Fleming & Spicer, 2002). It is unclear from my study whether the cynicism and disidentification present in FLS's talk substantively contributed to their capacity to effectively resist the organizational relations of domination that they believed were impeding their health equity work.

Limitations of the study

The main methodological limitation of this research project was that it was a secondary analysis, which presented a few challenges. Because I did not design the data collection instruments to address my specific research questions and I did not conduct data collection, I could not tailor the instruments to my inquiry or ask follow up questions during data collection to explore certain areas in more detail. To address this, I limited my investigation to research questions that the existing data were able to answer (Szabo & Strang, 1997).

I was not able to theoretically sample because I started my analysis after both phases of data collection had concluded. I used a few strategies to mitigate this. The health authority I selected as my site had the largest data set of the four health authorities involved in ELPH Study 1. I selected this health authority hoping that the large number of focus groups (14) and interviews (2) would be sufficient for data saturation (Szabo & Strang, 1997). In my analysis, I also paid attention to negative exemplars that illuminated the contradictions and complexity of the topic that would have otherwise emerged from theoretical sampling (Saldaña, 2013).

In the analysis process, I could not use traditional strategies for rigour such as member checking to validate study findings. However, as I described in Chapter 3, I had ongoing conversations with an original member of the study team and reviewed research reports written by the team to gather information about the study context.

A related concern about secondary analysis is whether the findings remain relevant in present day, given changes in the social, cultural and political context since the data was collected (Ruggiano & Perry, 2019). Data collection, which happened in 2014-2015, was conducted early in the implementation of the Core Functions Framework and immediately after the release of the 2013 Guiding Framework for Public Health. The Guiding Framework was updated and re-released in 2017, which meant that this work continued for some time after data collection. In addition, given that in 2024, many public health systems in Canada are still in the early stages of taking system-wide action on health equity, my findings on the dynamics of early implementation of this kind of change continue to be relevant.

Another limitation of this study involves the specific characteristics of the participants. As I noted in Chapter 3, all participants were women, most of whom were Bachelor-educated, had worked in public health for an average of 8.8 years (and therefore received their education during a particular time period), and primarily worked in positions with an individual practice focus. These characteristics undoubtedly shaped the discourses in circulation among them and therefore the study findings cannot be generalized to a different group of participants. Exploring how these characteristics may have impacted the findings is an area for further inquiry.

Three Phase 1 focus groups contained one or two managers, which meant that FLS might have been less likely to candidly reveal their thoughts and feelings due to manager-worker power relations. The remainder of the focus groups and interviews contained only FLS. That the discourses I identified were similar in focus groups with and without managers suggests that the perspectives of frontline staff were adequately represented in the findings.

Reflections on my method

The critical poststructural framework I used in this thesis project was beneficial in that it allowed me to consider the roles of power *and* agency in shaping FLS's experiences of health equity, which enabled me to take seriously both the organizational challenges FLS faced in their health equity work as well as their capacity for creative navigation and resistance to those challenges. The incorporation of organizational theory was an exciting innovation that allowed me to examine how the relationships between FLS and other actors in the organization influenced health equity work, which allowed me to discover the importance of FLS's perceptions of senior leaders' values and actions to the implementation of top-down initiatives.

Longitudinal qualitative analysis allowed me to identify changes over time in FLS's perception of health equity and of the organization, adding nuance to my findings, but the contribution of comparisons over time was limited as I could not relate the changes I found to specific organizational policies, initiatives or trends in order to make meaningful conclusions.

Finally, the analytic method I used, Critical Thematic Analysis (CTA) (Lawless & Chen, 2019), had some clear benefits over more straightforward thematic analysis outlined, for example, by Braun and Clarke (2006). The key contribution of CTA is that the researcher links the themes found in the data to macro social, political and cultural discourses. This method invited me to repeatedly turn my attention to how the micro individual, micro relational and meso organizational discourses in circulation among FLS were connected to macro level discourses, which allowed me to identify, for example, that the discourse of individual needs was deeply concerning because it echoed neoliberal ideologies, which have been linked to increasing inequities (Baum, 2011; Labonté & Stuckler, 2016; Pauly et al., 2009). Therefore, this analytic method enabled the critical approach I took in this project.

Implications for public health practice

What are the implications of these findings for health equity informed action? What actions might (or ought) various actors in a public health organization take to promote health equity? I used a critical poststructural epistemology to frame this study. A critical perspective would highlight that a modern public health organization is characterized by relations of domination that operate through the corporate hierarchy, in which those at the top have more material control of resources and organizational structures than those at the bottom. This implies that the actions of senior leaders shape what is possible for FLS's action on health equity, as prior research has established and as the FLS in my study affirmed.

A poststructural perspective, however, asserts that FLS's ideas and actions are not wholly determined by the organizational conditions they find themselves in. All actors have agency, even those at the 'bottom level' who have relatively little material control over their work. The various ideas and actions that FLS described holding and taking in resistance to official organizational direction and rhetoric can be explained by this agency. A poststructural perspective would also consider that the ideas and actions of 'higher ups' are also constrained by various factors, a notion that was very rarely present in any of the discourses in circulation among FLS. The contribution of a critical poststructural approach is that it asserts that both FLS and senior leaders have agency and that both FLS and senior leaders are shaped by their organizational environments.

Therefore, using a critical poststructural approach to discuss who has the responsibility and the capacity to take action to promote health equity must take into account both critical and poststructural ideas about how power operates in the organizational context: all actors have agency, and some actors have more organizational power than others.

Senior leader action

What implications do this study's findings have for the actions of public health senior leaders? My findings and the organizational theories I used to explain those findings suggest that senior leaders should approach health equity initiatives knowing that the translation of top-down directives into frontline action will be complex and often subject to resistance due to leader distance and organizational cynicism, among other factors. Given that health equity is ethically and affectively charged for many FLS and therefore perhaps even more subject to organizational cynicism and therefore resistance than other kinds of top-down initiatives, how can senior leaders take action at the top that practitioners can see translating into health equity for clients and communities? Specifically, how might formal organizational health equity change initiatives such as the equity components of BC's Core Functions Framework find success?

The most obvious strategy is to remove the barriers described in the organizational discourses articulated by FLS. FLS in this study outlined a series of organizational barriers that prevented them from doing the health equity work that they felt was ideal and to which they were ethically committed. They suggested that organizational changes such as more funding, generally for public health and specifically for extra and structurally focused activities, bolstering of universal programs, more professional autonomy and increased scope and support for working upstream would allow them to do better health equity work with clients and communities. Many of these organizational elements are under the purview of senior leaders in the health authority, although some – such as funding for public health – fall under the jurisdiction of government level policy makers. Removing such barriers might work to lessen FLS's organizational cynicism if this demonstrated to FLS that the values of senior leaders were at least in part aligned with their own.

Involving frontline staff in organizational decisions also offers a potential avenue for working across and perhaps mitigating leader distance. For example, Valaitis et al.'s (2016) examination of the implementation of the Ontario Public Health Standards in six public health units described how a top-down provincial initiative managed to involve staff in early policy development as well as later operational and program planning. Being engaged in implementation helped strengthen the meaning staff attached to the standards and increased their understanding of the changes as well as their buy-in.

The challenge of bottom level-higher up alignment

The suggestions I provided in the previous section rely on the assumption that alignment between senior leaders and frontline staff is possible and desirable for promoting health equity in public health organizations; that leader distance and organizational cynicism are detrimental to the work of health equity and should be mitigated. I would argue that much of the literature containing recommendations for senior leader action on health equity implicitly or explicitly relies on a traditional management approach, similarly assuming that senior decision makers should set priorities and establish structures for health equity work and if this is done well, frontline staff will carry out this work according to direction. On one hand this is true: a number of researchers have observed that the commitment and support of public health senior leaders is necessary to enable frontline practitioners to promote health equity (McPherson et al., 2016; Valaitis et al., 2016; van Roode et al., 2020) and many of the FLS in this study agreed with that assertion. Many organizational frameworks or recommendations for health equity like the ones advanced by Cohen et al. (2013), Lambton Public Health (2017) and the National Collaborating Center for the Determinants of Health (2018) also make the implicit assumption that organizational capacity for health equity action is strengthened when senior leaders and frontline practitioners are aligned in their normative orientation to and understandings of health equity. I do not dispute the spirit of this assumption.

However, a vast body of literature from organizational and management studies – including much conducted in health systems – has been preoccupied with misalignments between leaders and followers, which suggests that some degree of misalignment is common, if not inherent, to organizations. True to the thrust of that literature, I have shown that the organizational discourses of FLS in this study paint a stark picture of misalignment and mistrust between FLS and senior leaders, at least from the perspective of FLS. In addition, the discourses at work among FLS demonstrated that the direction of senior leaders did not translate straightforwardly into frontline action. FLS navigated organizational constraints in multiple ways, including various forms of resistance, with their actions reflecting their own understandings of what was morally appropriate action under those constraints.

Traditional organizational scholarship would argue that misalignment must be managed and mitigated in order to achieve organizational goals (e.g., Weber, 1978). However, more recent organizational scholars have taken the view that resistance and tension might be a productive force for change and innovation (Greenhalgh et al., 2004; Jansson, 2015). Indeed, a poststructural perspective on the findings of this study has shown that frontline practitioners have significant agency and, as I discussed in the section on organizational cynicism, their resistance to top-down initiatives and prescriptions has the potential to be a generative force that contributes to the promotion of health equity.

In the context of public health action on health equity, then, what happens if (or more likely, when) there is mismatch between actors in a hierarchically structured public health organization with respect to the value, definition and practice of health equity? Is full alignment a reasonable aim or expectation? Does the expectation or the pursuit of full alignment foreclose generative possibilities for dialogue and creativity?

One example of a top-down organizational strategy that intentionally harnessed the generative potential of resistance and tension was Ingham County (Michigan) Health Department's internal dialogue process, which aimed to transform the ways that department policies and practices impacted health inequity (Bloss, 2010). The change process was top-down in that it was initiated by management, but was somewhat bottom-up in that key participants were midlevel staff, although they were supported by senior leaders with resources and access to organizational power. Despite this, tensions arose when senior leaders were invited into the dialogue process – staff were cynical about senior leaders' sincerity and senior leaders were alarmed that staff were recommending action at structural levels. However, the dialogue process was used to bridge hierarchical and ideological distances and find a collective way forward. This method for health equity organizational change exemplified a critical poststructural approach to health equity action in an organization – it allowed staff to set the definitions and priorities for the scope of the work; relied on the action of senior leaders to carry out material change; and harnessed tension, difference and resistance as sources of knowledge.

Frontline staff action

If, as a poststructural perspective asserts, FLS always have agency and power regardless of organizational constraints, the key question is how they might navigate the organizational environment in ways that best enable them to work towards health equity, which they value highly. What strategies might they use that allow them to maintain a personal and professional sense of ethical integrity and identity? What are the possibilities and limits of different kinds of resistance, particularly in the face of neoliberal individualism and the bureaucratization of public health organizations? Organizational cynicism and disidentification, although they may be emotionally satisfying, generate group cohesion among FLS and offer an alternative, perhaps more comprehensive, picture of the work of health equity than official organizational rhetoric alone, risk leaving the relations of power that produce organizational constraints materially untouched. However, disidentified and cynical talk used in service of disobedience, defiance and collective organizing might have the potential to challenge such relations of power.

Work by critical nursing scholars offers examples for how frontline staff might take social and political action to resist organizational constraints. For example, as a response to the bureaucratization and corporatization of nursing practice wrought by Canadian healthcare reform, Rankin’s paper on *The Nurse Project* describes using consciousness raising with nurses and nursing students to “collectively unveil our participation in the discourses that subordinate and trouble our practices in order to produce practical actions through which we might confront and re-organize our work based on what we know” (Rankin, 2009, p. 284). One such practical action might involve the strategic use of charting and documentation to register the structural factors affecting care into the official organizational record, thereby coopting organizational trends of bureaucratization to make visible the devalued knowledge and ethical orientations of nurses (Pauly et al., 2009; Rankin, 2009).

These strategies invite frontline staff to use the relationships and tools available to them to critically assess how organizational discourses and practices harm their work and their clients, imagine how they might creatively push back against or subvert such constraints and participate in collective action. Regardless of what actions in resistance FLS choose to take, they would benefit from engaging in critical self-reflection, evaluating how their discursive and material practices (both in alignment with and in resistance to organizational directives) impact their work, their clients, people at other levels of the organization and organizational structures, and whether these practices allow them to move towards their ethical ideals of both service level and structural level health equity. Ultimately, the outcomes of health equity action must be measured at the level of population outcomes, not in terms of organizational dynamics.

My focus in this chapter on implications for action among FLS and senior leaders of course ignores those at the levels of hierarchy in between. In Chapter 5 I described how FLS emphasized that the support of their local managers was essential to their health equity work. Middle managers are key actors in organizational change (Birken et al., 2018; Embertson, 2006; Radaelli & Sitton-Kent, 2016) and recent work by the National Collaborating Centre on the Determinants of Health (2020a) on the role middle managers can play in health equity is unique. My findings also do not capture the roles of actors outside the top and bottom of the health authority's organizational hierarchy, such as policy makers or clients. The health equity understandings and work of FLS are intimately tied to these other actors in various ways, although exploring those relationships is beyond the scope of this study.

Implications for the concept of health equity in public health

This study also allowed for an interrogation of the concept of health equity in public health. Two key findings from my study call health equity's usefulness into question: that the structural elements of health equity are not within the professional purview of FLS and that the term can be used to contain diffuse and contradictory meanings.

Holding FLS responsible for health equity

This thesis rests on the critical theoretical assumption that effective health equity action to decrease health inequities necessarily works to examine and mitigate the impacts of structural systems of domination. However, most FLS in this and other empirical studies reported that they did not have the ability to take structural level health equity action due to organizational constraints, which prevented them from doing even minimal work to address SDOH for clients and communities, let alone the further upstream causes of the causes (Braveman & Gottlieb, 2014).

As I noted earlier in this chapter, this issue is widespread. Public health in Canada is, in theory, fundamentally concerned with systemic inequities. The BC public health policy documents that I have referred to in this thesis (Ministry of Health Services, 2005b; Province of British Columbia & Ministry of Health, 2013) noted the importance of systemic and structural action to address inequities. However, public health's position within the health system, its underfunding and undervaluing compared to acute care and the challenges it faces to acting on non-health determinants of health limits its scope of work and therefore its impact (Carey et al., 2014; Guyon et al., 2017; Potvin, 2014). This is particularly true when public health nurses, whose professional scope and culture of practice mostly remain within the realm of one-on-one service provision, make up the core public health workforce (National Collaborating Centre for Determinants of Health, 2015; Public Health Agency of Canada, 2008). Theoretically, public health as a field has a broad, whole-of-society scope, but within an organizational context, this scope tends to narrow.

Therefore, if frontline public health practitioners most often do not have the purview, resources or permission to take action to materially redistribute power and resources, is it reasonable to hold them responsible for health equity work? This question mirrors McIntyre et al.'s assertion that public health practitioners should not be held responsible for inaction on the SDOH. They argue:

> If action on the SDOH is fundamentally about public policy directed at reducing structural inequalities, then who is to blame for not facilitating action – public health workers who feel most comfortable in individual, behaviorally-oriented preventive activities; civil society organizations who should be advocating for enlightened policies to the policy elite and/or motivating the public to call for such action; health and health-related decision makers who perpetuate downstream responses; researchers who fail to translate the overwhelming body of research to all of the above; or should we blame a hegemonic sociopolitical system that is shifting ever more to the right? (McIntyre et al., 2013, p. 7)

As evident in this study and others, holding FLS responsible for health equity generates significant moral and emotional distress due to FLS's inability to address the structural factors that produce the health inequities they witness among clients and communities. Therefore, I would argue that FLS should not be the primary targets of top-down organizational change efforts to promote health equity, unless action is taken at more senior levels of the organization to ensure that FLS have the scope and resources needed to act structurally – in short, to remove the barriers they face to swimming upstream. One Canadian example of such action is the creation of social determinants of health nurse positions in Ontario public health units, which explicitly allowed public health nurses to "shift their approach to health care from largely biomedical and behavioural (e.g., a focus on lifestyle choices) towards acknowledging and acting on the social conditions that affect health and improve health equity" (McPherson et al., 2016, p. 5).

In the absence of profound changes to how public health practice is structured, another option is to reframe health equity at the frontline as a purely downstream concept, something that can be implemented within the very specific scope of a frontline public health provider. A narrowed version of health equity, one that takes into consideration how structural factors impact clients' experiences and access to health promoting resources but does not attempt to shift those factors, might be more appropriate for one-on-one service delivery. In that case, client-centered care, cultural safety or accessibility (Cusack et al., 2017; Papps & Ramsden, 1996) might be more fitting concepts than health equity; indeed, many FLS in my study reported that these aims and concepts were already present in their work and that they used similar terms more often than health equity. However, this narrowing would be unlikely to lessen the moral distress experienced by practitioners, especially if resource scarcity and bureaucratization continued to constrain their work. Explicitly narrowing FLS's focus to solely downstream interventions is also an example of the kind of depoliticization of health equity and public health action that many public health scholars have roundly critiqued.

The dilution of the meaning of health equity

As demonstrated by the multiple discourses I identified in this study, health equity was not a homogenous concept among FLS. The only conceptual element of health equity that all FLS in the study agreed on was that it concerned inequalities (but not necessarily inequities). Otherwise, definitions of health equity ranged from systemic to individual, upstream to downstream. If health equity was able to contain so many meanings, including the discourse of individual needs, has it become so dilute as to lack conceptual usefulness?

Wildgen and Denny (2020) suggest that the widespread and imprecise use of the concept of health equity has involved “a considerable emptying of its semantic and political content” (p. 247). Health equity’s original articulation was inherently linked to social justice and social transformation, but it has become so conceptually slippery that health equity action can now legitimately include lifestyle interventions or access to services, both of which are intended to mitigate the downstream impacts of structural inequities but do not challenge the sources of those inequities.

In this way, Wildgen and Denny argue that health equity has become an ‘empty signifier’, a term whose definitions have been extended so far that it ceases to have concrete meaning. Health equity, in their eyes, has been emptied of its moral orientation towards justice (which would require challenges to the social order) thereby “[allowing] diverse actors with different interests to rally around an idea that is divested of any specific content and [obscuring] what would otherwise be irresolvable conflicts and contradictions” (Wildgen & Denny, 2020, p. 249). However, the authors note, an empty signifier such as health equity can be discursively productive, in that it allows actors to gesture towards fairness without taking potentially contentious political action to achieve it, thereby maintaining systems of domination and inequity. This kind of discursive move can also generate confusion about the meaning of terms like health equity, creating yet another barrier to coordinated action (Heller et al., 2024). This dilution of meaning may in part explain why the proliferation of health equity as a term and concept in public health has been accompanied by “limited and sometimes self-undermining engagement with systemic causes of inequities, including issues of power, coloniality and their manifestations through systems of oppression" (Plamondon & Shahram, 2024, p. 1).

I am not suggesting that FLS intentionally used health equity as an empty signifier. Indeed, FLS did not generally use the term health equity, but preferred terms that were 'a bit more practical', whereas Wildgen and Denny argue that the term health equity is becoming increasingly abstract. Instead, I am concerned that an unexamined dilution of meaning has the potential to empty the broader project of health equity of its moral imperative to take a politicized approach to inequities. In my study, the "conflicts and contradictions" in FLS's diverse definitions of health equity were sometimes interrogated but rarely resolved. Instead, it seemed that many FLS were able to feel that they were doing good by doing health equity, in any form. This conceptual malleability might present a roadblock to public health action that substantively addresses inequities in health and the social and structural determinants of health.

Implications for future research on health equity in public health

One of the most interesting unresolved questions emerging from this project is whether and how the ways in which FLS navigated organizational constraints, including disidentification and cynicism, were generative. Did FLS's strategies for navigating constraints expand their ability to promote health equity? Did they materially increase health equity for clients and communities? What was the impact of FLS's adversarial construction of the organizational hierarchy on health equity work and the outcomes of that work? More broadly, how might disruption, tension, resistance, "conflicts and contradictions" (Wildgen & Denny, 2020, p. 249) be made visible and mobilized by FLS to advance action on health equity? What other ways of navigating constraints were not used by FLS but might also be productive? These research questions evoke a poststructural conception of power as something that is negotiated at every level of the organization and place agency squarely in the hands of FLS.

My methodology took a constructivist theoretical orientation, focusing on the talk of frontline staff in order to illuminate the discourses in circulation among them. However, all discourses understand a phenomenon from a particular limited angle (Talja, 1999). Comparing the perspectives of FLS with policy documents or the ideas of other organizational actors could be used to answer related research questions. For example, my study design did not allow me to identify whether the BC public health policy documents created to articulate organizational initiatives to promote health equity shaped the health equity discourses in circulation among FLS – this is an area for further research. An examination of health authority policy documents and other instruments related to the Core Functions Framework (Ministry of Health Services, 2005b; Province of British Columbia & Ministry of Health, 2013) and the Guiding Framework for Public Health could enable one to trace the path of an initiative such as the Inequalities Lens, in part to assess whether these policy documents had an impact on FLS and their work.

The majority of FLS in this study believed that health equity was not prioritized in decisions made by health authority senior leaders. However, studies of public health leaders conducted in BC during the same time period as this study reported that senior leaders valued health equity and were working to prioritize it (Pauly et al., 2017; van Roode et al., 2020). Empirical research done with public health leaders in North America has also found that they understood health equity as ensuring access to services and health promoting resources or as structural, although the former understanding was more common (Knight, 2014; McPherson et al., 2016; Pauly et al., 2017). Public health leader articulations of health equity in the literature, therefore, are at least somewhat similar to those of FLS in this study, contradicting FLS's assertions that their priorities are not the priorities of senior leaders.

Even when they valued health equity, leaders reported facing barriers to translating health equity priorities into organizational change. Indeed, van Roode et al. (2020) remind us that “values are not enough”, that “creating a core value for health equity throughout the health system is fundamental… but not sufficient to ensure prioritization” (p. 162). Barriers faced by leaders included a lack of policy maker commitment to health equity and the resultant challenges of diverting health care resources upstream, as well as a lack of research evidence and staff capacity to interpret it (Orton et al., 2011; van Roode et al., 2020). Some of the barriers that leaders described are the same as those FLS described: a lack of resources, a medicalized health system focused on acute care, a target and outcome culture and the complexity of measuring health equity impacts (Javanparast et al., 2018; Orton et al., 2011; Pauly et al., 2017; van Roode et al., 2020). There is, however, insufficient research on the relationships between frontline and senior level articulations of barriers to advancing health equity. Therefore, to better understand the implications and possibilities for senior leader action, we might ask: How do senior leaders understand the barriers to health equity action that FLS name? What constraints do senior leaders experience? How do the constraints experienced by senior leaders relate to those experienced by FLS?

We also do not know what senior leaders’ accounts of FLS are. Do senior leaders subscribe to a bottom level vs. higher up construction of how health equity work plays out across the organizational hierarchy? Comparing the discourses of FLS with the discourses of senior leaders in the same organization (and perhaps of those in between or outside of the organizational hierarchy) would allow for an exploration of how the ideas in circulation among and between organizational actors impact health equity work, and specifically, the implementation of top-down health equity initiatives.

The critical organizational theoretical approach I used in this study allowed me to pay attention to how frontline public health practitioners perceived their position and role in the work of health equity within a hierarchical organization. This study has generated new research questions on how dynamics across the organizational hierarchy impact health equity work. Where health equity work is being done in public sector organizations, it will be done in a hierarchical environment. Under these conditions, is the distance between leaders and followers inevitable? Research on health equity that looks across the organizational hierarchy, investigating how organizational dynamics and the practices that take place along those dynamics impact health equity work, as well as the ethical experiences and professional identities of people within the hierarchy, might allow us to better understand why organizational commitments to health equity are not making their intended impacts on populations.

Broadly, this study has also demonstrated the value of organizational theory for the study of health equity ideas and actions in organizations. Future research on health equity must take power and agency, especially of frontline workers, seriously. Organizations are political systems and therefore all organizational action is political, in that it involves interests, values and power (Langley & Denis, 2011). A critical organizational approach to the study of health equity in public health holds promise for further investigation in this area.

Despite the critical orientation of this project, I chose to limit my analysis primarily to making connections between the micro and meso levels of the organizational context. The scope of this project did not allow me to consider in detail the relationships between macro level social structures, meso level organizational practices and micro level relationships and understandings of health equity. Such investigations might consider: What is the relevance of all FLS (and most frontline practitioners in public health) being women? What can a gendered analysis tell us about how practitioners experience the domination of the organization as well as how they respond to it, both in ways that challenge but also possibly reproduce that domination? What might other systemic analyses, for example, along the lines of race or class, tell us?

Finally, this study has surfaced a number of questions about the concept of health equity that warrant further exploration. Is health equity still a useful term for frontline staff? What conceptual, moral and practical elements does it offer FLS that they do not already have language for? Poststructural understandings of discourse tell us that where counter-discourses exist, there is possibility for dominant discourses to lose ground or to change (Talja, 1999). Which discourses of health equity have the most critical potential for health equity work in public health organizations? Alternatively, how might discourses that depoliticize health equity, such as the discourse of individual needs, be harnessed or challenged?

Conclusion

This study affirmed that health equity was held as vitally important by frontline public health practitioners. It showed that despite frontline staff rarely using the term ‘health equity’, they saw ideas of equality, equity, vulnerability and structural determinants as conceptual cornerstones of their practice with clients and communities. Overall, FLS’s understandings of health equity mirrored many discourses present in the public health literature on health equity and in key BC public health policy documents. FLS were wrestling with many of the same conceptual and practical problems and tensions that currently occupy public health scholars.

However, this study echoed the body of literature on health equity work in public health that has found that public health practitioners most often understand health equity action as the relatively downstream work of ensuring that clients have fair access to services. Practitioners less often understand health equity work as the more upstream task of acting on the structural determinants of health. Some of the identifiable reasons for this downstream focus were organizational, such as a scarcity of resources, the bureaucratization of public health practice, and a restricted professional scope for frontline practitioners.

One of the key differences between FLS's understandings and mainstream public health discourses on health equity was the discourse of individual needs, which relied on the premise that the application of a systemic analysis to public health practice produced inequities. This discourse has not yet been identified in studies of frontline public health staff in Canada. Identifying this perspective is important because the discourse poses a threat to politicized notions of health equity.

FLS understood themselves to be deeply invested in and intimately connected to the everyday practice of health equity, which was characterized by relationality and professional autonomy. However, FLS understood distant and out-of-touch senior leaders and the bureaucracy of the organization to impede health equity or to promote forms of health equity that were rigid, prescribed and inappropriate. This study has enriched the literature on barriers and enablers to health equity action in public health, showing that frontline staff perceive that their own organization produces numerous barriers to health equity work. Specifically, a scarcity of resources for health equity action, the bureaucratization of public health practice, an over-emphasis on targeted approaches, and a limited professional scope contributed to practitioners' sense that although they valued health equity, the organization they worked for did not.

Taking an organizational approach to studying health equity initiatives allowed me to draw attention to how power dynamics among actors in a Canadian public health organization shape how practitioners understand health equity work. For frontline staff, health equity work happens in the context of what they understand to be an adversarial relationship between themselves and senior leaders. The concepts of leader distance and organizational cynicism can help explain why such a construction exists: the disidentified and cynical orientations of FLS might be understood not only as an attempt to navigate organizational constraints but their own sense of self, identity and ethical commitments to clients, communities and health equity.

These findings point towards avenues for action to promote health equity in public health organizations, both for frontline staff and senior leaders. Frontline staff might self-reflexively look for opportunities to harness resistance and tension to materially challenge relations of domination and thereby health inequities. Senior leaders wanting to implement top-down health equity initiatives might remove organizational constraints for frontline staff so they can carry out health equity work in ways that have positive impacts on inequities faced by clients and communities, or they might look for ways to ensure that frontline values substantively shape such organizational initiatives so that they can be implemented with the enthusiasm and expertise of frontline staff.

The findings also draw attention to concerns about the usefulness of the concept of health equity in public health. If frontline public health staff are prevented by organizational constraints from doing work that reflects the full scope of the term health equity, real movement on health equity will never be achieved by public health organizations. Frontline staff will continue to face the moral distress inherent to seeing the problem but not being able to act on it. A further threat to the concept of public health comes from its ability to contain many meanings at once, including neoliberal individualist ideas. Naming and negotiating the contemporary conflicts and contradictions of health equity will support the field of public health to ensure that health equity retains the politicized underpinnings that are so vital to its success.

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Appendix: Organizational Context and Timeline

This appendix contains the report I created to familiarize myself with the organizational context of the BC public health system in 2005-2015. It includes a description of the organization, the public health renewal initiative and the specific focus on equity that was a key part of that initiative. Significant dates are listed in Table 2. The table also includes dates for data collection for the Equity Lens in Public Health (ELPH) Study 1, of which this thesis project was a part.

The BC public health system

The BC public health system is organized into five health authorities, each of which deliver services in five geographic regions; the First Nations Health Authority, which delivers services to First Nations people across BC; the Provincial Health Services Authority, which coordinates specialized provincial services; and the Ministry of Health, which allocates resources, sets goals and provides policy direction (Pauly et al., 2013).

BC public health system renewal

In response to public health crises in the 2000s such as SARS and drinking water contamination, national public health organizations and think tanks called for the renewal of the Canadian public health system to ensure reliable and high quality service delivery (Tomm-Bonde et al., 2013). BC's approach to renewal took the form of the Core Functions Framework, which defined the parameters of public health work and emphasized the importance of evidence-based practice. Two key documents marked these major policy shifts: the Core Functions Framework (Ministry of Health Services, 2005a) and the Guiding Framework for Public Health (Province of British Columbia & Ministry of Health, 2013, revised in 2017). To support the Core Functions Framework, evidence reviews were conducted that summarized the available evidence in each program area, and model core program papers were released that outlined the components of each program area; these were meant to guide program and service delivery.

The equity lens

The 2005 Core Functions Framework document was the first to introduce the ‘Inequalities Lens’ as one of two cross-cutting approaches to delivering all public health services; the other was the ‘Population Lens’. The initial description of the inequalities lens focused on the importance of attending to differences in health status by intervening in root causes via the upstream determinants of health as well as ensuring that ‘vulnerable’ or ‘at-risk’ populations received more services. The 2013 Guiding Framework shifted the terminology to ‘inequities lens’ and described public health’s role in health equity as reducing inequities primarily through targeted universalism in services, although there is mention of intersectoral, policy and upstream action as well.

Table 2:

Timeline of key events in the BC public health system and key dates in ELPH Study 1

Date	Event
2001	52 health authorities in BC merged into five (Kent et al., 2017)
2003	BC public health renewal initiative begins (Province of British Columbia & Ministry of Health, 2013)
2005	Release of Core Functions Framework (Ministry of Health Services, 2005a)
2006-2010	Publication of Core Functions Framework evidence reviews and model core program papers
2009	The *BC Public Health Act* replaced the *BC Health Act*, giving more clarity to the public health system's unique roles and responsibilities (Ministry of Health Services, 2005a)
2010	Healthy Minds Healthy People plan released, guiding provincial work on mental health and substance use (Ministry of Health Services & Ministry of Children and Family Development, 2010)
2011	Adoption of Key Result Areas by health authorities, which were created by the BC Ministry of Health (Pauly et al., 2013)
Nov 2012	ELPH Pilot Phase 1 focus group conducted
2013	Release of Guiding Framework for Public Health (Province of British Columbia & Ministry of Health, 2013)
Jan 2014	ELPH Phase 1 focus groups/interviews
Jun-Nov 2015	ELPH Phase 2 focus groups/interviews
2017	Revision of Guiding Framework for Public Health