LET'S TALK: REDISTRIBUTING POWER TO ADVANCE HEALTH EQUITY

SUPPLEMENT 2 – PUBLIC HEALTH ROLES IN ADDRESSING POWER IMBALANCES IN THE CANADIAN CONTEXT: SUMMARY OF INTERVIEWS AND CONSIDERATIONS

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This document is one of three supplements that delve deeper into the concepts introduced in *Let's Talk: Redistributing power to advance health equity*.[1] *Supplement 1 – The evidence base for focusing on power imbalance as a root cause of health inequities*[2] and *Supplement 3 – Additional frameworks for conceptualizing and analyzing power*[3] are also available for your review.

INTRODUCTION

The concept of power is an important contributor to health and health equity and has been theorized by researchers for many years. Increasingly, the notion of power has also been used in various ways in public health practice in the United States, United Kingdom and Australia. In this document, we sought to understand how power is understood in Canada. Below, we discuss themes from 16 interviews conducted with Canadian public health practitioners and community organizers to find out how or if power is currently recognized and applied in the field of public and community health in our country.

A brief note on methodology

Interviews were conducted between December 2021 and March 2022. The list of interviewees was developed over time, starting with interviews of NCCDH Advisory Board members and former NCCDH staff and using a snowball approach until 16 interviews were conducted.

A set of questions was developed to guide the interviews. The interviews were conversational in nature and did not adhere strictly to the questionnaire. Question topics ranged from ideas around general conceptions of power, frameworks and tools currently used to conceptualize power, sources of power and inequities, roles of governments and public health to shift power, and key policies and practices that affect power imbalances. We also asked whether the interviewees were aware of current Canadian instances where power has been used to advance health equity.

CONCEPTIONS AND SOURCES OF POWER

As described in the documents *Let's Talk: Redistributing power to advance health equity*[1] and *Supplement 3 – Additional frameworks for conceptualizing and analyzing power*,[3] the literature offers multiple conceptions of power and several potential applications to practice. Similarly, the various practitioners and thought leaders interviewed suggested many ways of conceiving of power.

For many, power was equated with the ability to define or influence reality and to implement a vision, similar to Martin Luther King's definition of power as the ability to achieve purpose and bring about change.[4] Interviewees also understood power to operate at many levels: not only at the interpersonal, institutional and structural levels but also at the individual and community levels. Different interviewees focused on each of these levels, and some named the need for frameworks that move between them. One interviewee believed that one needs to first build power within individuals and only then move to building community power, though other interviewees did not concur. More frequently, collective community power was identified as what is needed to achieve structural change — in one interviewee's words, "True power is when things are created together" — along with the need for a vehicle (e.g., an organization) for sustaining and supporting collective power.

The people interviewed discussed how systems of oppression, such as structural racism, capitalism and colonialism, introduced and sustained power dynamics that are still present today. They asserted that "power over" has been practiced by settlers in Canada for ages and that has resulted in great harm. They also viewed capitalism (and neoclassical or neoliberal capitalism specifically), racism, imperialism and colonialism as forms of structural power. Those were named specifically as tools that extract wealth from people and from the land, which can lead to more power for those leading the extractive processes. Processes like Truth and Reconciliation,[5] which acknowledge and build awareness of the harms of these systems, are needed to tackle these forms of power.

Practitioners and leaders deemed relationships to hold power, and the various types of relationships — between people, between communities, with the earth — inform who you are accountable to and who you are accountable with. The more connected an individual is through networks of people in relationship, the more power one has.

Several interviewees offered specific frameworks for understanding power. One described a spectrum of power from a community's perspective with the following levels: "We don't exist; we exist but don't matter; we matter but only to a point; we are inevitable." Another offered the Advocacy Coalition Framework[6] as a framework for thinking about power. Its six steps include making meaning of evidence for people in light of their values; shaping opinion; framing people's beliefs about problems and solutions; setting the agenda; building coalitions around that agenda; and mobilizing it all — the evidence, public opinion, communications, agenda and coalitions — to force politicians to respond. This is similar to the three faces of power framework described in *Let's Talk: Redistributing power to advance health equity.*[1]

An intuitive understanding of the third face of power was also reflected by some interviewees who identified how our world view impacts how we perceive power. Evidence and knowledge were named as forms of power, though current beliefs (often hidden or implicit) about what is legitimate evidence and who are legitimate knowers support power structures that hinder progress toward equity. According to some interviewees (and the literature), world views are sometimes more important than scientific evidence as the level of importance accorded to data may depend on how it fits into someone's world view.

Notably, several people also mentioned that an important source of power is which world views and cultures are centred, whether deliberately or not. Dominant Eurocentric and neoliberal world views that value individualism and support forms of racism prevent progress toward equity. Indigenous world views that centre relationships, interconnection and generosity do not currently guide our practices and policies. Consistent with the evidence cited in *Supplement 1*,[2] interviewees proposed that centring the voices of Indigenous Peoples and other racialized peoples would shift this and lead to structural change.

Discussing power explicitly as an intervention was new for many interviewed. Most do not think of or talk about their work as building power, but they believe that advancing health equity requires a focus on power. When asked to consider their work from the perspective of power, there was recognition that some work public health is already doing, such as community engagement, can be considered and intentionally used for building power.

CURRENT POWER HOLDERS

Participants discussed who currently holds most power in Canada when it comes to decisions that affect health equity. Elected officials and political leaders were named as people with power, as well as those that contribute directly or indirectly to their political campaigns or parties (political donors). However, senior officials and bureaucrats were also perceived as having considerable power, especially in sectors that influence health. Those who have significant financial resources (e.g., people who own, privatize and financialize housing; those with inherited wealth) also hold disproportionate power. Corporations and industries involved in the extractive industries, and their lobbying groups, were also named as influencing health immensely. Finally, within the public health sector, physicians, medical officers of health, the Canadian Nurses Association and, more generally, those with a biomedical orientation (which, in the pandemic, has included epidemiologists) hold more power than others. This list of power holders reflects sources of power named in the literature, as discussed in the other documents in this series.[1–3]

Groups forced into marginalization, including racialized people and communities, people and communities living with low income, sexually or gender diverse (2SLGBTQI+) people and communities, older adults, women, and people with disabilities, were identified as having less power. One interviewee specified that power has been taken — stolen — from these groups.

While public health's position within the medical care system contributes to its power, it also lacks power relative to both the medical care system and society, at least in part because the general public does not understand what public health does or what advancing equity means. The medical care system as a whole holds power, especially in comparison to some other groups focused on equity (e.g., those working on housing or poverty reduction). However, several interviewees pointed to the need to build infrastructure to organize and mobilize public health and health care workers to advance equity. Other interviewees identified the need to educate the general public and, in particular, community leaders about public health's role, including how it differs from medical care (e.g., focus on populations, well-being, social justice, upstream determinants). Another pointed to the need to change public health's mandate to focus on addressing inequity.

POLICIES AND PRACTICES THAT MAINTAIN POWER IMBALANCES

Interviewees named a wide range of policies and practices that maintain power imbalances and inequities in Canada. The issue raised by the greatest number of interviewees was that government is the primary source of revenue for non-profit organizations. This results in non-profits primarily providing services. While they may not be explicitly prohibited from conducting organizing and advocacy activities, they fear that their funding will be reduced if they do so. This risk aversion often results in the lack of an independent voice — that is, community members and leaders — willing and able to push for policy and structural change. By rewarding a small number of large non-profits, government funding models create competition between community-based organizations, further enhancing barriers to the strong organizing and to the truth-telling necessary to advance equity. This also impacts non-profit organizations' capacity as they must spend time applying for competitive funding, aligning their activities with externally imposed metrics and preparing reports.

A number of other systemic factors that maintain power imbalances were identified by interviewees:

Electoral system: In Canada, including first-past-the-post elections (vs. proportional representation or ranked-choice voting, for instance) and the campaign finance system (e.g., donations by developers in municipal elections influence local housing policy and land use decisions). The electoral system also leads to politicians focusing on popular issues rather than what is needed to advance equity.

Taxation system: The lack of significant taxation of assets aside from income, and the low level of taxation both on higher income and wealthy individuals and on corporations.

Economic ideology: The value placed on neoliberal ideology as the main driver of economic and political policies, including:

- The prioritization of economic growth above all other measures of progress, and the associated influence of corporations and industry (e.g., the fossil fuel industry).
- The privatization and/or commoditization of housing, goods and spaces that should remain public and/or that are foundational human rights.
- The dismantling of employer responsibility for worker health, safety and well-being (intensified over the last few decades) and the reduction in the ability of workers to influence policy and workplaces (e.g., disempowerment of workers via barriers to unionization leading to reduced union membership, unions not being responsive to the changing environment).

Other governmental infrastructure: Education, child welfare, correctional services, employment and other infrastructure were designed, built and run mainly by White people and are imposed on racialized peoples, while also being underfunded due to paradigms of austerity.

Jurisdictions and local municipalities lacking relative influence and budget: When compared to provincial and federal governments, local government lacks influence and funds even though they are best positioned to work with communities.

Specifically within public health, interviewees pointed to:

- The marginalization and defunding of public health. While the medical care system continues to grow, prevention and work on the determinants of health is underfunded and deprioritized.
- The lack of public health advocacy and organizing.
- The structure of governmental public health — for example, provincial public health has obstructed the ability of local public health to conduct Health in All Policies (HiAP).
- Public health's excessive focus on evidence and our own knowledge and expertise, and not partnering with and supporting the leadership of communities impacted by inequity.

CURRENT EFFORTS IN CANADIAN PUBLIC HEALTH THAT CONTRIBUTE TO BUILDING POWER

Through the discussions, participants identified many examples of what public health in Canada is already doing to build power to advance equity. These include:

- Using community health centres as community-organizing hubs, expanding from service provision (and returning to the original conception of community health centres).
- Centring the voices of people with substance use disorders to advance harm reduction policies.
- Organizing diversity, equity and inclusion committees that have the necessary authority to make changes and to demand that people with too much power relinquish it.
- Funding community development work, with leadership development as a positive by-product.
- Increasing the focus and understanding of public health practitioners when it comes to topics like economics and capitalism, in order for public health to be positioned to engage and contribute to changing related policies that affect health.
- Supporting the organizing of workers, with public health partnering with them on issues like paid sick days.
- Building intersectoral partnerships that centre those most impacted in places with little organizing infrastructure.
- Expanding how we make the case and advocate for determinants of health investment in a way that speaks to more people, tapping into values they hold.
- Carrying out HiAP initiatives.
- Formally reallocating resources to organizations led by Indigenous Peoples or other racialized peoples, enabling them to organize, support and provide services as they see fit in dialogue with the communities they serve.

PUBLIC HEALTH ROLES AND ACTIONS TO ADDRESS POWER IMBALANCES

Based on the literature reviewed (see *Supplement 1 – The evidence base for focusing on power imbalance as a root cause of health inequities*[2]), the contextual information provided by interviewees, and the various frameworks examined (see *Supplement 3 – Additional frameworks for conceptualizing and analyzing power*[3]), a set of potential roles and associated strategies that public health can use to rebalance power and advance health equity has emerged. Canadian public health should consider the following actions, all of which involve public health leadership, courage and risk-taking:

Centre the voices of those most impacted by inequity in all our work, including in problem definition, issue prioritization, identification of potential solutions and decision-making. This must include:

- Building relationships and trust with communities who have been forced into marginalization.
- Following the lead of Indigenous, Black and racialized groups (e.g., Indigenous-led health care partnerships) and other groups forced into marginalization.
- Increasing community control over public health decisions at the local, provincial and federal levels, including structuring formal community leadership and governance into public health decision-making (e.g., representation on public health boards from communities living in marginalized conditions).
- Changing our research processes to lift up the perspectives and ways of doing things that come from people who live in marginalized conditions.

Refocus energy on structural root causes of ill health and inequities.

- Increase our focus on determinants of health, particularly issues with far-reaching impacts like economics and immigration.
- Release reports that are truth-telling on these subjects. Conduct more advocacy on them, connecting them to health equity.
- Do more advocacy in support of community-led campaigns on determinants of health and build the infrastructure within public health to do advocacy on determinants of health in allyship with organizing groups, networks of organizing groups and social movements.

Create mechanisms through which public health can conduct advocacy, for example, by creating associations that reduce the political risk to any single agency or organization.

Support community organizing and community-organizing networks.

- Public health agencies should fund non-profits — with a priority to organizing groups that truly work directly with populations forced into marginalization and centre their voices — to organize and advocate explicitly and to develop leaders intentionally.
- Financial support should include funding for grassroots community and worker organizing in communities forced into marginalization at levels sufficient to enable them to build community power. This can be achieved by shifting a percent of the funding public health uses to contract with non-profit service providers to support community and worker organizing, by finding additional sources of funding and by advocating for reallocation of funds from the medical care system.
    - Make funding available for the full spectrum of organizing capacity, from seeding organizing to mature organizing groups.
    - Ensure that a range of organizations (e.g., non-profits, community health centres, service providers) and a range of organizing models and approaches are eligible.
    - Fund organizing groups working on a range of determinants of health and with a range of populations who live in marginalized conditions.
    - When needed, support their capacity to organize and advocate (e.g., understanding laws and policies related to advocacy, supporting their fundraising efforts for advocacy work).
    - Partner and work with community- and worker-organizing groups where both the public health agency and the community-organizing group are robust and ready, centring joint work on the priorities of the members of the organizing group.
    - Seed organizing where it is not already happening. Use models like Equity-focused Intersectoral Practice (EquIP)[7,8] the Canadian Partnership for Children's Health and Environment (CPCHE to organize across sectors, centring communities who have been forced into marginalization. Community health centres can also be organizing hubs.
    - Support social justice movement building by allocating staff time and resources to it.
    - Work with organizing groups using an inside/outside strategy[a] in which each partner carries out activities that match its strengths and those activities are coordinated.

[a] An inside/outside approach is one in which public health strategically partners with community- and worker-organizing groups. Public health is positioned inside government and/or has inside access to government decision-makers. Organizing groups are positioned outside government and have outside access to government decision-makers. Each can play a role that matches their positionality and constraints. They can coordinate activities, publicly or in private.

Fund networks of local organizing groups to work together to form alliances across issues and across differences, and fund networks of local organizing groups working on the same issue in different jurisdictions to work together to advance change at the provincial and federal levels.

Conduct more equity-focused HiAP work, especially on issues that have broad impacts on health equity such as our economic and immigration systems. This includes:

- Allowing medical health officers to advocate and build local relationships for HiAP.
- Pushing for increases to provincial and federal budgets for determinants of health, along with clear parameters to ensure that spending improves root causes of poor health and health inequities.
- Organizing non-health agencies to support and fund equity-focused organizing groups.
- Stimulating public dialogue about taxation and the need to raise revenue to invest in the determinants of health.
- Supporting our democratic political system.

Fund and/or lead narrative change initiatives that advance equity. Examples of changes to public narratives include moving from a focus on individualism to a focus on relationships, interconnection and belonging; from stigmatizing drug use to an understanding of its root causes; and from having racialized stereotypes to understanding that all people deserve dignity and respect.

- Centre the world views of Indigenous communities in public heath work.
- Use the narrative change process to raise consciousness among participants about societal problems and shared grievances, power, and who is responsible for and who can address those problems and grievances.
- Based on common values and beliefs identified in the narrative change process, learn to frame public health work so that it appeals to a broader range of the population.

Shift public health training curriculum and the focus of research to include more about power, oppression and equity.

- Academic public health should deepen its understanding of power, especially as it relates to changing the systems and structures that determine health outcomes.
- Public health training should include content on how power is and has been connected to health and racial equity; how power has been conceptualized and frameworks for understanding power; the connection between structural racism, as well as other forms of oppression, and power; community organizing as a model for building power with communities forced into marginalization; power analysis; critical and political economy perspectives; and public health interventions that build community power using real-world case studies from academic, governmental and non-profit public health and community health.
- Curriculum should also include more attention to critical social theory, which foregrounds issues of power, and to different ways of knowing (shifting away from epidemiology and biostatistics as the foundations of public health science).
- Professional public health development and updated public health core competencies should reflect the current skills necessary to address power and equity.

CONCLUSION

Power is a concept that, if well understood, can be applied to public health practice and used as an intervention to advance health equity. This document explored various ideas, conceptions and examples of power from a selection of current community and public health leaders. The results of these interviews were used to propose several considerations and strategies that public health practitioners and leaders can initiate today to start redistributing power to achieve health equity.

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