

# Public Health as Social Justice? A Qualitative Study of Public Health Policy-Makers' Perspectives

by

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for the degree of Doctor of Philosophy

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## Abstract

*Background:* 'Social justice' is routinely identified as a core value for the field of public health. Yet, outside of the theoretical literature it is seldom accompanied by a robust definition or an explanation of what it requires for policy and practice. If social justice is intended to be, or ought to be, a core value in public health, its meaning and normative requirements must be understood and articulated in a way that is applicable to, and practicable for, public health policy and practice. This study takes a first step in responding to this charge by (1) exploring public health policy-makers' perspectives on the meaning and role of social justice in their practice, (2) examining the extent to which distinct perspectives on social justice exist in different programmatic areas of public health (chronic disease prevention and public health emergency preparedness and response), and (3) analyzing these perspectives in light of existing normative social justice theory.

*Methods:* This study involved qualitative, semi-structured interviews with public health policy-makers purposively recruited from municipal, provincial, and federal public health organizations

in Canada. Twenty interviews were conducted, analyzed via thematic analysis, and subsequently interpreted in light of, and situated within the context of, normative social justice theory.

*Findings:* Two overarching themes emerged from the interviews, in addition to three unique themes from interviews with participants involved in chronic disease prevention and three themes from those involved in public health emergency preparedness and response. Social justice was not uniformly interpreted among study participants, and the meanings and roles attributed to social justice appeared to be influenced, in part, by the perceived goals and contextual features that belong to the programmatic area of public health in which they practiced.

*Conclusions:* The findings of this study provide an understanding of how the meaning and role of social justice is interpreted by public health policy-makers. They point to key areas in normative social justice theory where further attention ought to be directed, as well as key areas in the public health policy and practice context where normative social justice theory could enhance and refine the value's practical interpretation and role.

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# Chapter 1

## Introduction

*“...the historic dream of public health...is a dream of social justice.”*

- Dan E. Beauchamp, 1976

‘Social justice’ is central to the vocabulary of public health. It is routinely identified as one of the field’s ‘core values’ and is regularly assessed as being critical for the achievement of desirable and ethical population health outcomes (Buchanan, 2008; Commission on Social Determinants of Health, 2008; Edwards & Davison, 2008; Gostin & Powers, 2006; Krieger & Birn, 1998; Lee, 2012; Powers & Faden, 2006; Thomas, Sage, Dillenberg, & Guillory, 2002; Wilson, 2009b; World Health Organization, 1986). In fact, social justice is often described as the ‘foundation of public health’ (Krieger & Birn, 1998; Levy & Sidel, 2006; Powers & Faden, 2006; Tod & Hirst, 2014). This pronouncement has decades-old roots, but was perhaps most eloquently and famously articulated by philosopher Dan Beauchamp in his now forty-year-old article, *Public Health as Social Justice* (1976), to which I owe a debt for inspiring the title of this thesis. Appreciating that public health is an ethical enterprise, Beauchamp argued that “public health should be a way of doing justice” (p. 8), and that, as above, “...the historic dream of public health...is a dream of social justice” (p. 6).

Social justice is also frequently invoked outside of the scholarly literature in the public health policy and practice context. The term is featured in the mission and values statements, ethical frameworks, and guidance documents of public health organizations across Canada and internationally. For example, a ‘commitment to social justice’ is included as a ‘core value’ in the Public Health Agency of Canada’s (2008) statement on the core competencies for the practice of

public health in Canada, and consideration of ‘social justice implications’ is included in Public Health Ontario’s (2012) *Framework for the Ethical Conduct of Public Health Initiatives*. It also figures prominently in some of the field’s most seminal and celebrated works. Indeed, social justice is affirmed as a ‘fundamental condition for health’ in the Ottawa Charter for Health Promotion (World Health Organization, 1986), and is identified as the motivation for forming the World Health Organization’s Commission on Social Determinants of Health (2008).

Social justice—so the argument typically goes—affects the way people live, their consequent chance of illness, and their risk of premature death (Commission on Social Determinants of Health, 2008). Injustice,<sup>1</sup> then, is considered to be responsible for dramatic differences in health between populations (Wilkinson & Pickett, 2010). An oft-cited example of this is the correlation between socioeconomic positions and the social gradient in health; those occupying lower socioeconomic positions will tend to have worse health than those occupying higher socioeconomic positions (Marmot, 2005). Hence, given public health’s mission to protect and promote population health, it is generally accepted that public health ought to be concerned with social justice (Venkatapuram, 2016).

Yet, despite the ubiquity and stature of the term, outside of the theoretical literature it is seldom accompanied by a robust definition or an explanation of what it is that public health’s ‘commitment to social justice’ actually requires for policy and practice (Edwards & Davison, 2008; Fafard, 2012; Trotter, 2008). In addition, it is rarely acknowledged that social justice is a complex, multifaceted concept with a rich pedigree in moral and political philosophy. The sheer variation in the sorts of concerns, rights, and obligations (among other things) that have been

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<sup>1</sup> For the purposes of this thesis, ‘social justice’ and ‘justice’ are treated as synonyms. I return to this point in Chapter 2.

proffered as being essential to social justice in this philosophical literature pre-empt a claim that its meaning is self-evident, and reveals that ‘social justice’ likely precludes a single (or simple) interpretation or application. Trotter (2008) articulates this apparent problem in the following way:

...such assertions are accompanied by the presumption that the meaning of these terms is already settled and generally known. This is especially true in the domain of academic public health, where “social justice” is typically offered as a lynchpin of public health theory...and cited to justify simpleminded dogmas about “eliminating health disparities” and so forth, yet virtually never characterized in its theoretical details or acknowledged in its multiplicity of competing and incompatible forms. (p. 452)

There also appears to be a general skepticism, discomfort, or disinterest—I am not entirely sure what it is—in attempting to rectify this state of affairs. That is, there appears to be a reluctance to specify the contents of social justice and wade into the murky, complex, and contested realm in which social justice is theorized. While difficult to substantiate, I argue that the prevailing perfunctory treatment of social justice in the public health literature is indicative of this attitude. A recent article published in *The Lancet*, for example, titled *Chronic Diseases—The Social Justice Issue of Our Time* (Horton, 2015), somehow neglects to indicate what it is exactly that makes chronic diseases a social justice issue in the first place, or what it is about chronic diseases that displaces other public health issues from being awarded this title. Another example comes from the aforementioned core competency statement published by the Public Health Agency of Canada (2008), which in fact prefaced its inclusion of social justice as a core value by stating that social justice, along with other core ‘values and attitudes’ enumerated in the document, “have not been listed as specific core competencies for public health because they are difficult to teach and even harder to assess” (p. 3). Rather than addressing the considerable challenge that this raises for the field of public health—its *core value* and *foundation* are

considered neither teachable or assessable!—this document and many others appear content to simply leave social justice in its underdeveloped and underspecified form and continue to invoke it when it seems convenient or advantageous to do so.

This general trend is problematic for a number of reasons. First, it may act to render the normative commitments and force of social justice impotent. Social justice is a normative concept, and so it is typically used to say something about how things ought to be or how we ought to act. I consider it fair to assume that the term is intended to possess this normative quality when it is invoked in public health.<sup>2</sup> That is, it is likely intended to say something about how public health policy and practice *ought to be arranged and implemented as a matter of social justice*. If this can be assumed, then appeals to social justice in public health should be seen as implying that attention ought to be paid to the ethical concerns of social injustice, and that public health activities ought to align with the ethical imperatives of social justice (Giacomini, Kenny, & DeJean, 2009). Thus, if the particular normative concerns, considerations, and commitments of social justice are not articulated or are unclear when the term is invoked in public health, its prescriptive function will be dysfunctional; it will end up saying very little about how public health policy and practice ought to be arranged and implemented. By contrast, a sufficiently robust conception of social justice should be able to provide insight into the major controversies and situational challenges that are often confronted in public health, and enable the interrogation of the content, scope, and justification of public health policy recommendations (Gostin & Powers, 2006; Venkatapuram, 2009). It may also be able to help put contemporary public health issues in perspective and supply policy imperatives

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<sup>2</sup> I consider this a fair assumption given the stature and importance bestowed to the term and the manner in which it is typically invoked in public health (i.e., in values statements).

regarding future public health action (Krieger & Birn, 1998). As Beauchamp (1976) contended, robust conceptions of social justice have the capacity to “furnish a symbolic framework or blueprint with which to think about and react to the problems of the public” (p. 4). Conceptual underdevelopment or muddiness will therefore render such a normative framework either barren or disordered, which increases the likelihood that the ideals and aims of social justice, whatever they may be, will not be realized. If social justice is truly perceived to be a core value for public health, then this should be considered unacceptable.

Second, because values (like social justice) influence policy goals, decisions, and conduct, and figure in explanatory models of the health policy-making process (Fischer & Forseter, 1987; Giacomini, Hurley, Gold, Smith, & Abelson, 2004; Rein, 1976), it is imperative that their meaning and nature be specified and well-understood. So, while it may be easier to ‘commit’ oneself to social justice and foster agreement about its status as a core value if the term remains underdeveloped and underspecified, this will tend to obscure or conceal disagreements about how the value ought to be interpreted and applied. Left open to interpretation, the value of social justice will likely elicit diverse, if not divergent, views among public health professionals and organizations regarding the proper goals and obligations of public health. We can simply look to the ‘multiplicity of competing and incompatible forms’ of social justice found in the theoretical literature in order to illustrate the myriad ways in which the value might be interpreted. For example, some accounts will contend that the job of social justice is to ensure that the worst off in our society are brought above a certain threshold of well-being (a variant of what might be called ‘sufficientarianism’), whereas others will contend that social justice requires one to act in accordance with that which tends to maximize the greatest amount of welfare for the greatest number of people (a variant of what might be called ‘utilitarianism’). Each of these interpretations, in addition to the myriad other ways in which social justice may be

interpreted, will supply different views about what should be counted as a social injustice, what should be done through public health action to remediate social injustice, and what should be done through public health action to promote social justice.

Without narrowing or specifying what social justice means when it is invoked in public health, the term is capable of accommodating these varied and often conflicting views and will conceal disagreements on this matter. This is problematic insofar as these sorts of tacit disagreements are likely to confuse policy deliberation (Giacomini et al., 2004), stymie progress on important public health initiatives, or because they may simply lead to muddy and imprecise policies. However, there are more insidious implications. The varied and potentially conflicting views of public health professionals and organizations, even if they remain tacit, are no less capable of influencing the design and implementation of public health policies and practices, which in turn impact the public's health. In the worst case, leaving the value open to desultory interpretation may translate into ethically dubious, inconsistent, and unsound policy and practice decisions, which may in turn contribute to the creation, maintenance, or exacerbation of social injustice—the very outcome against which the value is intended to militate.

I therefore take the following assumption as a point of departure in this thesis: if social justice is meant to serve, or ought to serve, as a value for public health (as I believe it should), and if it is meant to provide, or ought to provide, any semblance of practicable ethical guidance for public health policy and practice in this role (which I also believe it should), then we must seek to explore and understand its meaning, role, and normative requirements, and subsequently articulate these characteristics in such a way that is applicable to, and practicable for, public health policy and practice (Buyx, Killar, & Laukötter, 2016). If this point of departure is reasonable, which I believe it is, then we must turn our attention to addressing the questions that naturally follow from it: what is it that we are committing ourselves to in public health when we

commit ourselves to social justice? What is it that we *should* be committing ourselves to? As a ‘core value’ of public health, what does social justice require in terms of how it is organized and practiced? What *should* it require?

Fortunately, these questions—at least the normative ones—have not been entirely neglected. An emerging body of philosophical literature in the domain of public health ethics has supplied plausible responses to these questions via the development of theories that focus primarily on questions of justice in health and public health (Daniels, 2007; Powers & Faden, 2006; Ruger, 2010; Segall, 2009; Venkatapuram, 2011). In addition, more general theories of social justice (i.e., those developed without a particular focus on, or concern with, health and public health) provide the possible foundations upon which further answers to these questions could be constructed (e.g., Rawls (1999), Sen (2009)). Yet, it is hitherto unclear how this body of philosophical literature, with its ‘multiplicity of competing and incompatible forms’, to quote Trotter again, might interact with, let alone inform, the interpretation and application of social justice in public health policy and practice. One might be inclined to interpret this as a mere issue of knowledge translation, requiring one to simply select a theory from this literature and translate it to the public health policy and practice context. But, which theory should be selected? Which theory should we prefer? Which would be most capable of supplying a satisfactory framework for policy and practice? These are difficult questions, though they are not necessarily unanswerable. They do not faze Wilson (2009b), for instance, who argues that “...finding a suitable normative framework for thinking about public health ethics and policy requires us, in the end to work out which account of justice we should prefer” (p. 190). Through a mixture of normative argument and conceptual analysis, this philosophical project would involve ‘reasoning out’ which account of social justice we should prefer and then asking public health professionals to conform their actions to it (Wilson, 2009b).

While the philosophical project is no doubt an important one, I am skeptical as to whether normative theory developed from philosophical investigation *alone* can meaningfully inform or guide public health policy and practice without further empirical insights. This is because the philosophical project largely does not directly engage with practical, messy matters of public policy (Buyx et al., 2016). This means that no matter the degree of coherence, elegance, or soundness of philosophical theory, that theory may be unworkable in the ‘real’ world. Again, the philosopher may be unfazed by this. G.A. Cohen, for instance, believed that justice is not primarily about what we ought to do, but rather what we ought to think (Cohen, 2003). On this view, the practical import of theories of social justice may be of little consequence to their value (Valentini, 2011). To be fair, though, this is not true of all theories or theorists; many philosophers do in fact believe that a sound theory of justice ought to be action-guiding (Valentini, 2009). Nevertheless, if our goal is to understand how social justice ought to be conceived in order for it to be successfully pursued in policy and practice—in other words, for social justice to have the capacity to *operate* as a value in public health—then information about this messy context is crucial.

In contrast to the philosophical project, this pragmatic goal embraces the practical nature of ethics as an inquiry directed at ‘what to do’ rather than a mere theoretical inquiry directed towards ‘what is the case’ or ‘what we ought to think’ (Finlay, 2007). It acknowledges that the task of specifying and clarifying the values that form the basis for policy decisions and actions is both a theoretical and practical endeavour. Pursuing this goal necessitates engagement with the ‘realities’ of the context of public health policy and practice. For instance, it likely necessitates engagement with the views of those who have insights or experiences within the context of public health policy and practice (e.g., public health professionals), as those views may supply important information about contextual factors that may have practical or normative implications

for the pursuit of social justice (Gaertner & Schokkaert, 2012). Understanding such views is important because they might put constraints on what institutional and policy options (or reforms) advocated by theory are practically achievable (Lamont & Favor, 2014). Indeed, philosophical accounts of social justice that are theoretically coherent could be rejected by stakeholders responsible for implementing policy or affecting practice for reasons that may only be understood through engagement with those stakeholders.

Moreover, philosophy's general neglect of the practical matters of public health policy and practice means that important moral information about social justice itself may be overlooked. As Ives and Draper (2009) argue, there is "something lacking in an approach that appeals solely to abstract theoretical principles and rationality when the problems addressed are experienced in a particular context" (p. 250). The theoretical literature has consistently ignored the social context in which public health is practiced—the context in which the value of social justice is actually interpreted, negotiated, ignored, experienced, and pursued. A robust understanding of this context, including the considerations that shape or constrain what is perceived by those practicing in public health to be desirable or possible, may contribute to an understanding of the value's pragmatic features and role (Musschenga, 2005). As Sen (2009) argues, "there is clearly a strong case for not leaving out the perspectives and reasonings presented by anyone whose assessments are relevant, either because their interests are involved, or because their ways of thinking about these issues throw light on particular judgements—a light that might be missed in the absence of giving those perspectives an opportunity to be aired" (p. 44). Indeed, empirical research that engages these perspectives can help us to recognize which moral principles or considerations are most at stake in this context (Solomon, 2005).

This general disposition is reflected in Buchanan's (2008) recent assertion that, "[a]lthough the call for social justice is frequently voiced in public health, it is critically

important for the field to address major differences in definitions of justice found among the general public” (p. 15). While Buchanan’s focus on the general public is certainly not misplaced, in virtue of the arguments supplied above I believe it is also important, if not more important, to explore and address the perspectives of public health professionals, like policy-makers, on the meaning of social justice and the role the value plays in their practice. Because policy-makers are charged with developing and installing policies and standards that can have far-reaching implications for how public health is organized and practiced (and because they are among those responsible for interpreting how the value of social justice ought to figure in such policies and standards, if at all), their insights in this role are important and their views on this matter are critical. However, to date, there has been no empirical exploration of public health policy-makers’ perspectives on the meaning and role of social justice.<sup>3</sup>

Thus, if the value of social justice is to simultaneously impart conceptually robust normative guidance and be relevant and applicable to practice, it ought to be understood both in terms of the substantial theoretical insights afforded by normative social justice theory *as well as* the practical insights afforded by understanding the way(s) in which it is understood, experienced, and pursued in practice. In light of this, several hitherto unexplored questions arise that generally motivate this study:

- To what extent do the myriad conceptualizations of social justice in the philosophical literature, authored by those who possess the analytic wherewithal to carefully consider, construct, articulate, and defend (ostensibly) philosophically sound accounts of social

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<sup>3</sup> This claim is supported by my review of the relevant empirical literature on this matter, which occurs in Chapter 3.

justice, align with or interact with the ways that social justice is interpreted in the context in which it is experienced and pursued in public health policy and practice?

- How could an understanding of the practical experiences and perspectives of public health stakeholders provide insight into, or challenge the practical application of, normative theoretical contributions in this domain? Conversely, in what ways might an understanding of the practical experiences and perspectives of public health stakeholders provide insights into the ways in which normative theoretical contributions could inform the interpretation and application of the value of social justice in public health policy and practice?
- Would a more robust interaction between this theoretical literature and the experiences and perspectives of public health stakeholders result in a theoretically rich, yet pragmatic understanding of social justice that could enhance its role as a ‘core value’ that guides and justifies public health activities?
- Ultimately, might an attempt to establish a dialogue between theory and practice enhance the pursuit and achievement of social justice in public health?

The purpose of this thesis is to take a first step towards addressing these questions by seeking to understand public health policy-makers’ perspectives on the meaning of social justice and the role the value plays in their work, and by examining these perspectives in light of recent theoretical contributions in this area. In particular, rather than presuming that perspectives on the meaning and role of social justice will be uniform across different programmatic areas and contexts of public health policy and practice, this study explores the perspectives of public health

policy-makers working in two distinct areas in which public health is commonly organized and practiced: chronic disease prevention and public health emergency preparedness and response.<sup>4</sup>

There are four research objectives that guide this study:

1. To explore the perspectives of public health policy-makers regarding the meaning of social justice and the role the value plays in the context of their practice.
2. To examine the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health (chronic disease prevention and public health emergency preparedness and response) are similar or different in regards to the meaning and role of social justice.
3. To identify key areas of normative social justice theory that could benefit from being enhanced or refined given the findings from objectives 1-2.
4. To identify key areas in which normative social justice theory might help to enhance or refine the meaning and role of social justice in public health policy and practice given the findings from objectives 1-2.

These objectives are pursued with an eye towards informing a pragmatic conception of social justice that is normatively and conceptually robust yet suitable as a guide for public health policy and practice.<sup>5</sup>

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<sup>4</sup> The reasons for selecting these particular programmatic areas of public health will be discussed in Chapter 4.

<sup>5</sup> To be clear, this study does not aim to develop an account of social justice. Rather, the objectives listed are pursued with an appreciation that their achievement may inform the development of a pragmatic conception of social justice that is normatively and conceptually robust yet suitable as a guide for public health policy and practice.

There are four research questions that motivate the design and data collection for this study:

1. What are public health policy-makers' perspectives on the meaning of social justice and the role the value plays in the context of their practice?
2. To what extent are the perspectives of public health policy-makers involved in different programmatic areas of public health (chronic disease prevention and public health emergency preparedness and response) similar or different in regards to the meaning and role of social justice?
3. In what key areas should normative social justice theory in public health be enhanced or refined given this study's empirical findings?
4. Giving this study's empirical findings, in what key areas might normative social justice theory help to enhance or refine the meaning and role of social justice in public health policy and practice?

As will be described in greater detail later in this thesis, research questions one and two will be answered in this study via qualitative, in-depth, semi-structured interviews with public health policy-makers, and research questions three and four will be answered via an analysis of the empirical data generated from the first two research questions in light of the pre-existing philosophical literature.

In Chapter 2, I establish a conceptual and theoretical understanding of social justice by grounding the concept in the philosophical and public health ethics literature. This chapter seeks to provide a response to the question, 'What is social justice?', and aims in particular to examine the ways in which this question has been answered in the context of, or in relation to, public

health. As such, this chapter serves as the theoretical background for this study and constitutes the theoretical apparatus with which this study's empirical data were analyzed and interpreted. The chapter begins by noting that social justice defies simple or uniform definition. It proceeds by articulating a classic formulation of justice, which asserts that 'justice exists when individuals are rendered what is due to them'. The ways in which this definition have been interpreted and further specified by philosophers is then discussed, with particular attention paid to analytically distinguishing the different 'forms' that justice often takes—namely, distributive, procedural, and relational justice. Common elements that comprise different treatments of social justice are then synthesized with the hope that an overall sense of the conceptual landscape of social justice is produced. Greater theoretical depth is then sought by synthesizing and analyzing features and accounts of social justice that have been developed out of a particular concern with questions of social justice in public health. Efforts are subsequently undertaken to examine how social justice might be conceptually distinguished from the concept of health equity, another prominent value in public health. In particular, Powers and Faden's (2006) Twin Aim Theory of social justice is discussed as a focal point for the interpretative framework for this study.

Chapter 3 proceeds according to my argument that it is not only important to explore and understand the ways in which theoreticians have sought to advance our understanding of the concept of social justice, but also to understand the ways in which public health professionals interpret, conceptualize, and use this concept (if at all) in the context of public health policy and practice. This chapter therefore seeks to explore and situate my study's research problem and questions within the existing body of empirical literature that reports perspectives on the meaning and role of social justice in public health policy and practice. Ultimately, my review and analysis of this empirical literature indicates that, while social justice is routinely identified as an important value in public health policy documents and among the perspectives of those

engaged empirically on ethical issues and considerations in public health, very little empirical work has sought to explore perspectives on how this value is understood and used in public health. Among other findings, the review indicates that no studies exploring perspectives on social justice (or health equity, for that matter) have robustly engaged with the normative theoretical literature on social justice in order to situate or understand these perspectives.

Chapter 4 describes the methodology and methods deployed to answer this study's research questions. In particular, it again defends the utility of generating empirical information about the perspectives of public health professionals in order to advance a pragmatic understanding of social justice in public health. With the aim of exploring and understanding public health policy-makers' perspectives on the meaning and role of social justice in public health policy and practice, this study's methods involve qualitative, in-depth, semi-structured interviews with twenty public health policy-makers recruited from municipal, provincial, and federal public health organizations in Canada. This chapter also discusses the rationale for exploring the perspectives of policy-makers recruited from two distinct programmatic areas of public health policy and practice (chronic disease prevention and public health emergency preparedness and response).

Chapter 5 describes the findings from these qualitative interviews. The themes presented in this chapter speak to the ways in which the public health policy-makers I interviewed talked about social justice and shed light on the discursive role that different features and considerations of social justice played as situated within the participants' context of public health practice. The findings presented in this chapter respond primarily to this study's first two research questions by describing public health policy-makers' perspectives on social justice and the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health were similar or different.

Finally, Chapter 6 provides a refined analysis and discussion of the findings reported in Chapter 5 and examines these findings in light of this study's theoretical and empirical background presented in Chapters 2 and 3. Future directions for research, policy, and practice are offered, and the thesis concludes with a discussion of this study's limitations and the provision of explicit answers to the study's four research questions.

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## Chapter 2

### Theoretical background: Social justice

*“Strange justice that is bounded by a river or mountain! The truth on this side of the Pyrenees, error on the other.”*

- Blaise Pascal, 1670

This chapter establishes a conceptual and theoretical understanding of social justice (particularly as it has been interpreted and discussed in the context of public health), which constitutes the theoretical background for this study and the theoretical apparatus with which this study’s empirical data were analyzed and interpreted.

While the concept of social justice originates in philosophical discourse, it is widely used in many other disciplines and in ordinary language. In philosophy or otherwise, the concept of social justice defies simple or uniform definition given its capacity for normative interpretation. Indeed, it has been argued that entire monographs have been written about social justice without defining it (Hayek, 1978). Adding another layer of complexity to defining social justice is that a multitude of terms occupy similar conceptual space, like fairness, equality, and equity. This conceptual similarity may have etymological roots: the Attic Greek *isotes* was typically used to mean both justice and equality (Vlastos, 1997), and the classical Latin etymon *jūstitia* was typically used to mean something akin to fairness or equity (Oxford English Dictionary, 2015).<sup>1</sup> Finally, it is not uncommon for terms like ‘justice’, ‘social justice’, and ‘distributive justice’ to

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<sup>1</sup> A response to the question ‘what is justice?’ with ‘it is fairness’ or ‘it concerns equity’ should therefore raise concerns about circular reasoning unless further explanation is offered. In the same vein, the description of a situation as being ‘just, fair, and equitable’ requires an examination of whether these are synonyms being provided for rhetorical effect or whether each term is actually intended to describe distinct qualities of that situation.

be used interchangeably, even among philosophers (e.g., see Miller (2001), Rawls (1999)), which only fuels confusion about whether these terms have distinct meanings, roles, and scopes.<sup>2</sup> Hence, when the term ‘social justice’ is invoked, like in the assertion that ‘social justice is the foundation of public health’, we have a reason, defeasible though it may be, to be skeptical of whether a definite meaning is intended and whether a uniformity of interpretation is conferred.

The upshot of this conceptual and theoretical complexity and incertitude is that it is exceedingly difficult (if not infeasible) to supply a comprehensive ‘theoretical background’ of social justice, and perhaps even more difficult to establish a neatly bounded apparatus for data analysis that wholly accounts for this complexity and variance. Though, even if this were feasible, it would be unsuitable for the purposes of this study.<sup>3</sup> Rather, in this chapter I will discuss the body of theoretical literature that best frames and contextualizes this study’s

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<sup>2</sup> ‘Social justice’ and ‘justice’ will be used interchangeably in this thesis. However, it is worth noting the term ‘social justice’, insofar as it can be distinguished from ‘justice’ or other related terms, might sometimes be used to (a) refer specifically to justice at the societal level (that is, between society and the individual rather than between individuals) and the distribution of social, rather than private, goods, or (b) convey a critical perspective aimed towards social reform. Using the term in the former sense is sometimes helpful in order to delineate the ‘circumstances of social justice’. That is, it points to the requirement that there be a notion of ‘society’, which has a structure and social institutions capable of affecting the prospects of its members, in order for ‘social’ justice to be a workable ideal or value (Miller, 2001). It also typically denotes that the state is the primary institution whose policies and practices contribute to ‘social’ justice or injustice. Using the term in the latter sense is important, but I do not consider it to be much of a distinguishing characteristic, as I believe social justice, justice, distributive justice, fairness, and related terms are equally evaluative and/or prescriptive, and thus believe *all* are capable of carrying this critical characteristic. This reasoning is reflected in the following passage by Lamont and Favor (2014): “To claim that we should not pursue any changes...in light of a distributive justice argument is, by its very nature, to take a stand on the distributive justice of the current distribution and structures in the society compared to any of the possible alternative distributions and structures practically available.”

<sup>3</sup> Proceeding with a single definition or interpretation of social justice was also considered inappropriate as doing so would take for granted the conceptual and theoretical insights that may be conferred by other accounts, and would arbitrarily limit the conceptual and theoretical breadth of this study. Fundamentally, it would ignore the possibility that another theory (or set of theories) might provide more substantial, or simply different, analytic and interpretive insights to the study’s research questions, problem, and data. Another alternative, e.g., generating empirical data before any theoretical exploration occurs and then choosing a particular theory, or theories, as an analytic apparatus based on the nature of the data, was also considered to be less than ideal, as this would render my study design and data collection tools devoid of a robust understanding of the theoretical landscape, which would be unfortunate given the benefits of being able to recognize and respond to the contours of the theoretical terrain during these phases of study development and implementation.

particular research problem and questions, which will in turn form the basis of a theoretical ‘inventory’ from which this study’s apparatus for data analysis and interpretation can draw and evolve. Methodologically, this means this study’s theoretical analytic apparatus was not fully established *ex ante* (Salloch, Wäscher, Vollmann, & Schildmann, 2015). This strategy allowed me to remain inclusive in terms of theory prior to the generation of data, and afforded me the opportunity to consult a broad conceptual and theoretical inventory while permitting a narrowing of the analytic focus once data were generated.

In the first half of the chapter I therefore do not attempt an exhaustive review of the voluminous literature on social justice, but rather hope that, by synthesizing the common elements that comprise different treatments of social justice, an overall sense of the conceptual landscape will emerge. This discussion is intended to serve as a heuristic that can help in identifying and distinguishing the significant conceptual attributes and normative concerns, implications, and assumptions that might exist when the term ‘social justice’ is invoked. To this end, the particulars of theories of justice that have dominated contemporary philosophical interest and adorn introductory chapters to books on social justice, like John Rawls’s (1999) theory of justice as fairness, Ronald Dworkin’s (2000) theory of resource ‘luck’ egalitarianism, and Amartya Sen (1985, 2009) and Martha Nussbaum’s (2000) capability approaches, while of central importance to the philosophical study and pedigree of justice, will not be rehearsed here. Rather, given the nature and scope of my research problem and questions, greater theoretical depth will be sought in the second half of this chapter by synthesizing and analyzing features and accounts of social justice that have been developed out of a particular concern with questions of social justice *in public health*.

## 2.1 Conceptual foundations of social justice

In its most skeletal form, justice is often said to consist of the apportionment of goods and evils—benefits and burdens, advantages and disadvantages—to individuals in accordance with that to which they have a moral claim. Stated in its classic formulation, justice exists when individuals are rendered what is due to them (Buchanan & Mathieu, 1986; Cohen, 1986; Frankena, 1962; Miller, 2001; Sandel, 2009).<sup>4</sup> At the outset, it is helpful to be clear that the apportionment of goods and evils (or the evaluation of such an apportionment) can occur according to criteria other than what can be called ‘just-making’, including other ‘right-making’ criteria or justifications (e.g., efficiency, beneficence, charity, mercy, etc.). In other words, just-making considerations are only one species of right-making considerations (Mill, 1962 (1861); Nozick, 1974; Rawls, 1999).<sup>5</sup> For example, Tom giving Mary his coat when she is cold constitutes an act of beneficence, but not of justice (Buchanan & Mathieu, 1986).

To highlight this point further and to situate it within the context of health, the following example may be instructive. The mere fact that some people are in poor health is no doubt cause for moral concern and may provide substantial moral force to a plea to have such substandard health remediated. The fact that we might also consider the substandard health of some to be *unjust* can provide additional moral force to a plea to have such substandard health remediated. Thus, the identification of an injustice in the world may indicate a particular type, or perhaps

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<sup>4</sup> At this point it is important to note that ‘rendering to individuals what is due to them’ need not be understood simply in terms of ‘rendering’ actual *things*, like resources. Goods and evils, benefits and burdens, or advantages and disadvantages can also be understood in terms of the positive and negative ways in which individuals are treated, for instance, which can also be ‘rendered’ in accordance with that to which they are due. This distinction is further discussed in section 2.2.

<sup>5</sup> While this appears to be an uncontroversial claim, some (e.g., Plato) in fact construed justice as closer to the whole of morality (Buchanan & Mathieu, 1986). I would agree with Frankena (1966) that “this seems to be distributing justice a little thin” (p. 3).

even special type, of wrongness that requires remediation. It implies that a duty exists on one side (e.g., of society or the state), and a right on the other (e.g., of an individual or citizen), which the latter can claim from the former (Frankena, 1962; Mill, 1962 (1861)). The task, then, is to articulate the just-making criteria that should be used to identify the nature of such moral claims.

The idea that goods and evils should be rendered to individuals according to what they are due negates entirely arbitrary apportionment, and establishes that, unless there are just-making criteria requiring *differential* apportionment between individuals, every individual's interests and situations ought to be taken into equal account. Central to this idea is the acknowledgement of the impartial and universalizable nature of moral judgments (Gosepath, 2011).

However, there is good reason to believe that, at least for some goods and evils, all individuals do not have equal moral claims. Some individuals may have stronger claims, and some individuals may have no claim at all. These parameters are formalized in what is often referred to as the formal logic of justice, attributed to Aristotle, for which there seems to be significant agreement: 'Treat equals equally and unequals unequally in proportion to relevant similarities and differences' (Buchanan & Mathieu, 1986; Frankena, 1962, 1966; Mansbridge, 2005; Perelman, 1963; Sidgwick, 1907). Individuals are alike and unlike in myriad ways, so the pertinent task is to identify those similarities and differences relevant for justice. Some argue that nearly all debates over the proper conception of justice can be understood as controversies over which cases should be considered equal and which unequal (Gosepath, 2011).

The formal principle of justice—'treat like cases as like'—constitutes a necessary condition of justice, but does not articulate which similarities and differences are to be considered relevant or sufficient in such an assessment. Hence, a society can be formally just insofar as it treats like cases similarly but materially unjust due to the just-making criteria or

rationale it has chosen in its assessment of like and unlike cases (Frankena, 1962). Different theories of justice proffer these substantive components of justice, and as Daniels (2013) puts it, “will bake and serve this cake in different ways.”

One of the pertinent questions for this chapter, then, is how social justice has been discussed and theorized—how it has been ‘baked and served’—in the context of public health. Before moving on to address this question, though, more will be said presently regarding the forms and features that commonly distinguish the contents of justice.

## **2.2 Forms of justice: Distributive justice, relational justice, and procedural justice**

Broadly speaking, conceptions of justice fall into three categories: distributive, relational, and procedural.<sup>6</sup> As Jost and Kay (2010) note, it can be useful to distinguish between these forms of justice, but “little is gained by exaggerating or reifying such divisions” (p. 1143). A theory of justice may address any or all of these aspects (Jost & Kay, 2010).

As the name implies, *distributive* justice (sometimes referred to as ‘substantive’ justice) is concerned with how and why goods and evils—typically things like resources, properties, opportunities, and offices—are distributed. Accounts of distributive justice typically answer three questions: (1) Distribution of what? (i.e., the ‘currency’ of justice, sometimes referred to as the ‘distribuendum’ or ‘distribuans’); (2) Distribution to/among whom, and; (3) Distribution according to what basis or pattern?

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<sup>6</sup> Other ‘forms’ of justice not explicitly named here, such as restorative, retributive, reparative/corrective, and criminal justice are acknowledged but are left out of this discussion due to them being (a) in some senses applications or interpretations of forms of justice discussed here (i.e., restorative justice may be an operationalization of the demands of distributive justice), or (b) not typically considered to be within the scope of social justice (Miller, 2001). Other ‘forms’ of justice, including ‘global justice’ and ‘intergenerational justice’, may raise distinct normative concerns (e.g., justice between nations and generations, respectively), but likely do not fall outside of the conceptual rubric of distributive, procedural, or relational justice.

Importantly, ‘distribution’ here ought to be interpreted in its passive form, as in the ‘distribution of females in a society’. Accordingly, ‘distribution’ in the context of distributive justice may be better understood as ‘patterning’, where a ‘distributor’ need not exist. Where the act of distribution is active, this is often called ‘allocation’. Hence, some goods can be distributed in society but not necessarily allocated (e.g., health), both allocated and distributed (e.g., public health resources), but can never be allocated without at the same time being distributed. Distributive justice may concern itself with both allocation and distribution.

The distribuenda in a conception of distributive justice are what individuals are thought to be ‘due’ (or are proxies that are considered instrumental in bringing about what individuals are thought to be due), and can therefore be almost anything; however, because these are the things to which individuals ostensibly have a moral claim, they are typically assumed to have substantial social value (or disvalue, in the case of the distribution of burdens) (Miller, 2001). There is therefore no exhaustive list of distribuenda, but common candidates include: resources (e.g., income, health care resources), opportunities (e.g., educational, vocational), capabilities (e.g., to be healthy, to be able to participate in political life), and welfare (e.g., satisfaction of preferences, utility). The act of specifying the distribuendum or distribuenda in a theory of justice is a normative task, requiring one to establish the moral relevance of a particular good (and its distribution) to justice. As such, different theories invariably concern themselves with different goods according to the moral significance bestowed to such goods and the context in which they are developed or discussed. As an example, theories concerned with the distribution of the benefits and burdens of economic activity might focus on things like income and wealth. Theories of distributive justice that bestow special moral importance to health (i.e., ‘health justice’) might focus on the distribution of some measure of ‘health’ (e.g., self-reported health status), access to health care, the opportunities or capabilities individuals have to be healthy, or

the resources deemed necessary to bring about health. Ultimately, drawing the boundaries between justice-relevant and justice-irrelevant distribuenda depends partly on the capacities of social institutions to influence the distribution of such goods or evils and the degree of consensus in society about the value (or disvalue) of such goods (and evils) (Miller, 2001).

The pattern or basis of distribution corresponds to the varying criteria used to determine which cases ought to be treated as similar or different, and are often characterized as ‘material’ principles of justice (typically articulated in the form ‘according to *x*’, where *x* is the pattern or basis upon which distributions ought to be configured). Given the innumerable ways in which cases may be assessed as similar or different, again, no exhaustive list of material principles of justice exist. With that said, common principles include: need, equality, desert, utility, and supply and demand. For example, if it is believed that some distribuendum (e.g., health care resources) ought to be distributed ‘according to *need*’, then one believes those with greater need (however defined) ought to have an enhanced, enforceable claim to the distribuendum as compared to those with lesser need as a matter of justice.

A single principle of justice may be included or prioritized in a theory of justice (which are called ‘unidimensional’ theories), or multiple principles that cannot be reduced may be included or prioritized (which are called ‘multidimensional’ theories) (Sabbagh, 2001). This distinction between unidimensionality and multidimensionality is often linked to an additional distinction between the universal or particularistic (local) character of principles or theories of justice (Deutsch, 1975; Elster, 1993; Sabbagh, 2001; Walzer, 1983). Theories advancing universal principles (e.g., some forms of utilitarianism) assume the general validity of the principles (e.g., the principle of utility maximization), which is not significantly affected by the context in which they are applied. Theories proposing that principles have a particular validity are based on the notion that justice requires a reference to local context (Elster, 1993; Walzer,

1983). For instance, one might argue that justice requires the opportunity to vote to be distributed according to equality, Olympic gold medals according to merit, and income according to effort and contribution. In other words, the particular qualities of the distribuendum and the context in which it is distributed plays a significant role in providing normative justification in favour of, or in opposition to, a particular pattern or basis of distribution. Rawls's (1999) theory of justice as fairness, for example, is a multidimensional theory typically understood as being universal in scope, whereas Walzer's (1983) theory of justice is a multidimensional theory that is of the particular variety. Non-universal accounts of justice are often said to be promoting a 'separate spheres' view of justice, where the focus of justice is on one 'sphere' (e.g., education or health) in isolation from other 'spheres'. Accounts adopting the separate spheres view often make a stronger claim, arguing that justice in one sphere *ought* to be considered in isolation from justice in other spheres.

Of significance to theories of justice in the past half century are the principles of equality, priority, and sufficiency, so something brief will be said about each of these. Some argue that equality is implied, at least as part of some requirement or criterion, in nearly all theories of justice (Gosepath, 2011). Yet, this does not mean every theory of justice requires perfect equality, that equality is the only relevant principle of justice, or even that equality ought to serve as a material principle of justice (Jost & Kay, 2010). Egalitarians commonly distinguish themselves insofar as they value equality in itself; that is, egalitarians believe "[i]t is bad in itself that some people are worse off than others" (Parfit, 1998, p. 3).<sup>7</sup> Many egalitarians depart from strict equality in some way or another due in large part to the leveling down objection—the idea

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<sup>7</sup> There is tremendous variation in what is thought to constitute 'egalitarianism', so this description is necessarily oversimplified.

that equality for its own sake can become absurd or repugnant if it is reached by depriving people of some good, even if everyone has sufficient amounts of that good, simply in order for equality to obtain. Non-egalitarians, on the other hand, do not consider equality to be of intrinsic value (though it may be instrumentally valuable). For sufficientarians, the central concern is whether individuals have enough of a given good to satisfy justice, not whether everyone has an equal amount. As Frankfurt (1987) argues, “[i]f everyone had enough, it would be of no moral consequence whether some had more than others” (p. 21). Conversely, prioritariness argue that benefitting the worse off is the most important job of justice. The relative position of the worse off is therefore of no moral significance to the prioritarian (as it is for the egalitarian). Rather, as Parfit (1998) argues, “[b]enefits to the worse off matter more, but that is only because these people are at a lower absolute level. It is irrelevant that these people are worse off than others” (p. 13).

Much has been said thus far about distributive justice, which perhaps reflects the fact that it has historically dominated discussions of justice. *Relational* justice, sometimes referred to as interpersonal, interactional, or informal justice, arguably falls outside of this distributive paradigm by focusing justice concerns largely on the informal and formal treatment of persons through social interaction (Anderson, 1999; Young, 1990). Whereas distributive justice might be said to consist in a desirable distributive pattern, where justice requires us to aim towards realizing that pattern, relational justice requires a disposition to treat individuals in accordance with principles that express just relations (typically relations of social equality). Only when principles of just relations are satisfied (e.g., when individuals are treated with equality of standing or status) can the distributions resulting from those relations (e.g., of wealth, health, etc.) be considered just. As Anderson (2010) argues, “[t]he justice of distributions is derived

from an independent standard of the justice of agents, which involves conformity to principles of justice that regulate their conduct” (p. 2).

In essence, relational justice seeks to situate justice in its social and historical context (Young, 1990). For example, justice does not simply require the consideration of how goods and evils are distributed; it also (or solely, depending on the account) finds just-making criteria in how individuals (including institutions and the state) are related to the conditions in which people find themselves (Pogge, 2004). That is, relational justice adds a place “for those who have or share moral responsibility for the justice or injustice” (Pogge, 2004, p. 142). As a concrete example, an account of distributive justice that does not take relational factors into consideration may claim that an individual’s need should act as the sole criterion upon which the just distribution of health care resources should be assessed. By contrast, a relational justice account might instead, or in addition, claim that the justness of the situation must take into account how others relate to that individual’s need. If the state in fact created the conditions that led to a disparity in need for health care resources, then on a relational justice account that situation may be considered more unjust than a situation where a disparity in need is caused by other sources (e.g., by chance alone), and the state may be explicitly implicated in that injustice. Conversely, an unequal distribution of goods and evils may be considered just on a relational account of justice if that distribution resulted from the decisions and intentional actions of those concerned (Gosepath, 2011).

Much like the elements of distributive justice, many elements of social relations have been nominated as the focal point for relational justice. For instance, respect, power, privilege, status, truthfulness, propriety, honesty, responsibility, and dignity have all been proposed as being central to relational justice, shifting the attention of distributive justice towards the critical investigation of social phenomena like domination, subordination, exploitation, oppression, and

marginalization (Bies & Moag, 1986; Jost & Kay, 2010; Miller, 2001; Young, 1990).

Importantly, the relational justice paradigm attunes the attention of justice to *social group* differences (e.g., race, ethnicity, socioeconomic status), which is a variable that has arguably not been adequately captured by the aforementioned material principles of distributive justice.

There is some disagreement as to whether relational justice is, or ought to be, conceptually subsumed under the rubric of *procedural* justice (Bies, 2001, 2005; Bobocel & Holmvall, 2001; Colquitt, Greenberg, & Zapata-Phelan, 2005; Greenberg, 1993; Jost & Kay, 2010; Tyler & Blader, 2000). Procedural justice—or perhaps more commonly, procedural ‘fairness’—consists of applying just-making criteria to processes, like when making decisions about priorities for the allocation of resources, rather than directly to actual distributions or outcomes. Indeed, proponents of procedural justice argue that injustice (and justice) can obtain irrespective of distributive circumstances. For example, the fact that some individuals are given power they should not possess to decide particular issues might indicate a certain procedural injustice even if the distributive consequences of that decision accord with desired distributive principles (Miller, 2001).

Accounts of procedural justice contend that just-making criteria are more applicable to, or are more appropriate for, procedures rather than any pattern of distribution, that just procedures are able to guarantee just outcomes or distributions (i.e., *perfect* procedural justice), or simply that it is unlikely or implausible that substantive agreement will be reached on distributive principles of justice but that it is possible to instead agree upon procedural principles (Ashcroft, 2008; Miller, 2001). Accounts of procedural justice commonly concern themselves with process control and/or decision control. Jost and Kay (2010) sum up these two procedural features in their assertion that, as a matter of justice, “people want to know that they will have input into (and are therefore able to exert at least some influence over) the decision-making

process as well as the decision itself” (p. 1140). There are many factors or principles that have been considered relevant to procedural justice, chief among them being neutrality, consistency, accuracy, reasonableness, revisability, timeliness, inclusiveness, transparency, and publicity (Daniels & Sabin, 2002; Jost & Kay, 2010; Leventhal, Karuza, & Fry, 1979).

Much more could be said about the conceptual landscape of social justice. Indeed, a discussion of social justice would undoubtedly be enhanced by referencing and reflecting upon the broader political philosophy in which ideas or theories of justice are grounded, and the status of justice within comprehensive political theories. This falls outside the scope of this chapter. Furthermore, each element of justice considered above, such as the potential significance of ‘oppression’, ‘desert’, or ‘responsibility’ to justice, admittedly warrants volumes of further discussion (and such volumes certainly exist). Yet, for the purposes of this chapter and this study, where the theoretical landscape of social justice in the context of public health is the central focus, the mere acknowledgement of these important elements of justice is sufficient, with the proviso that they can be revisited in a more thorough manner if relevant in the data analysis stage. At any rate, the foregoing, I believe, provides a substantial conceptual background to the more pertinent, forthcoming discussion of social justice as it has been discussed in the context of public health.

### **2.3 Social justice and public health**

Krieger and Birn (1998) indicate that the statement ‘social justice is the foundation of public health’ emerged over 160 years ago during the formative years of public health as a movement and profession. In their view, the statement reflects the notion that public health is a public matter, and calls upon and nurtures “a spirit that has a compelling desire to make the world a better place, free of misery, inequity, and preventable suffering, a world in which we all can live,

love, work, play, ail, and die with our dignity intact and our humanity cherished” (p. 1603). This is no doubt a laudable aim for public health, and is one that is surely shared by most if not all of those working in the field of public health. Yet, framed in this rather evocative manner it appears significantly disconnected from the foregoing theoretical discussion (but is no less abstract). Expressed in this way, it seems to me to be less concerned with elucidating particular justice-based commitments for public health than it is with serving a more general advocacy role—a broad critique of the status quo or an appeal for reform. In this form, it is perhaps easy to commit oneself to social justice and still disagree bitterly about what should be done about concrete problems in public health (Miller, 2001).

By contrast, the relationship between social justice and public health was perhaps first explored in a way that aligns with the foregoing theoretical discussion by philosopher Dan Beauchamp (1976) in his article, *Public Health as Social Justice*. In this seminal article, Beauchamp argues that public health is an ethical enterprise committed to the notion that all persons are entitled to protection against the hazards of this world and to the minimization of death and disability, and that the benefits that accrue from the norms of what he calls ‘market justice’—a ‘dominant’ model of justice whereby people are only entitled to those ends that they have acquired by their own individual efforts, actions, or abilities—are woefully inadequate to assure full and equal protection of all human life. He eloquently elucidates the aims of justice, indicating that “justice means that each person in society ought to receive his [sic] due and that the burdens and benefits of society should be fairly and equitably distributed” (p. 3). Beauchamp acknowledges that competing just-making criteria exist (namely: merit, equality, or need—common material principles of justice), but in the end argues that all individuals are equally entitled to key ends, like health protection or minimum standards of income, and that, consequently, all individuals ought to equally share the costs of collective action required to

achieve this goal.<sup>8</sup> This reflects the broadly and predominantly egalitarian quality of much of the social justice discourse that has appeared in the public health literature since this article was published.

With that said, this more focused examination of social justice in public health has not been the norm.<sup>9</sup> Reporting results from a search of the *American Journal of Public Health* for articles that mention and discuss ‘justice’ (published between January 2000 to October 2005), Trotter (2008) found that, of 53 articles that addressed justice, only two offered a substantive definition of justice, and there was neither a single acknowledgment of the theoretical variation in conceptions of justice or a single defense of a particular conception of justice. Trotter concluded that the “vast majority of these articles simply presumed that everyone working in public health already knows what justice is” (p. 457). Gubrium and colleagues (2014) reached a similar conclusion: “[w]hile widely advocated, an explicit theory of justice is rarely identified” (pp. 121-122). Though, this point is not lost on all of those invoking the term in the public health literature. For instance, while the World Health Organization’s Commission on Social Determinants of Health (CSDH) argued that action on the social determinants of health and on health inequities was “dictated by a concern with social justice”, Michael Marmot (the

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<sup>8</sup> More precisely, Beauchamp argues that social justice requires controlling the hazards of this world to prevent death and disability through organized collective action shared equally by all, except where unequal burdens result in increased protection of everyone's health and especially potential victims of death and disability.

<sup>9</sup> In fact, it has only been relatively recently that health has begun to figure in the philosophical treatment of social justice. For example, the most prominent contribution to the philosophical literature on social justice—John Rawls’s 1971 theory of justice as fairness—framed health as a ‘natural good’, meaning it did not fall within the scope of social justice given that it was not considered to be directly or significantly socially produced (Rawls, 1999; Venkatapuram, 2011). This has prompted many, including Daniels (2007), Sen (2002, 2009), Nussbaum (2000), and Venkatapuram (2011), for example, to argue for the significance, if not centrality, of health to social justice, citing, among other things, the influence of social arrangements on health and the importance of health in securing opportunities and capabilities that are central to social justice.

Commission's chair) later expressed that "[t]he passion of the CSDH about social justice was perhaps not matched by the depths of our analysis of what we meant by it" (Marmot, 2011, p. x).

With that said, there is an exception to this perfunctory treatment of social justice in the public health literature. With the emergence of the field of public health *ethics* in the late 1990's and early 2000's, there has been a surge in the theoretical exploration and examination of social justice and its role in the public health context. The first scholastic articles exploring and, indeed, constructing the emerging field of public health ethics examined, or at least identified, social justice as a key value or ethical consideration in public health (Callahan & Jennings, 2002; Childress et al., 2002; Gostin, 2003; Kass, 2001, 2004; Thompson, Robertson, & Upshur, 2003). For instance, in her seminal article introducing an ethics framework for public health, Kass (2001) proposes that one should ask whether public health programs are "implemented fairly", a question she says corresponds to "the ethics principle of distributive justice, requiring the fair distribution of benefits and burdens" (p. 1780). Childress and colleagues (2002), as another example, suggest that two of the general moral considerations in public health involve "distributing benefits and burdens fairly (distributive justice)" and "the participation of affected parties (procedural justice)" (pp. 171-172).

In addition to the 'fair' distribution of benefits and burdens from public health activities, both Kass and Childress et al. locate at least part of the scope of social justice in addressing the social conditions that determine or impact health. Childress and colleagues argue that "[s]ocial injustices expressed in poverty, racism, and sexism have long been implicated in conditions of poor health" (p. 177), which both sets of authors consider to be public health's responsibility to

remediate as a matter of justice.<sup>10</sup> For example, Kass argues that it is appropriate, if not obligatory, for public health to reduce poverty, substandard housing conditions, and threats to a meaningful education. In a similar vein, Callahan and Jennings (2002) assert that “much of the research and expertise in public health throughout its history has shown how social deprivation, inequality, poverty, and powerlessness are directly linked to poor health and the burden of disease”, and that this corresponds to public health’s “strong orientation toward equality and social justice” (p. 172). As such, for many of the early contributors to the field of public health ethics, social justice in this context means/requires both a fair distribution of the benefits and burdens of public health activities as well as the remediation of deprivations, inequalities, or disadvantages in the social conditions that ultimately implicate poor health.

Kenny, Sherwin, and Baylis (2010) more explicitly situate their account of social justice in the relational paradigm. They suggest that, in traditional bioethics, the ‘principle’ of justice is primarily concerned with non-discrimination and distributive justice, which often includes questions regarding the just allocation of scarce resources. They go on to contend, at least implicitly, that a relational account of justice concerns itself with matters of ‘social’ justice (where distributive justice presumably does not). On a relational account of justice, Kenny et al. argue that what is of primary significance is fair access to social goods like rights, opportunities, power, and self-respect. As established in the first half of this chapter, the authors indicate that this relational justice account attunes attention to the context in which political and social

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<sup>10</sup> I have chosen not to rehearse the frequently cited social epidemiological evidence that links disparities in social conditions (e.g., socioeconomic status, race, ethnicity, income level, education, and so forth) with disparities in population health (Acheson, 1998; Black, Morris, Smith, & Townsend, 1992; Marmot et al., 1991; Marmot, Rose, Shipley, & Hamilton, 1978; Mikkonen & Raphael, 2010), as I assume this is familiar to anyone at least casually involved in public health. These data are undoubtedly important to social justice, but they do not answer which disparities should be assessed as ‘unjust’ nor why they should be evaluated as such. This task requires some conception of justice (Eyal, Hurst, Marchand, Norheim, & Wikler, 2013; Venkatapuram, 2009).

policies and structures are maintained and how they create inequalities in access and opportunity. Ultimately, Kenny and colleagues argue that relational social justice “enjoins us to correct patterns of systemic injustice among different groups, seeking to improve rather than worsen systematic disadvantages in society”, and “requires attention to the needs of the most disadvantaged” (p. 10).

Many of the ethical frameworks developed in the public health ethics literature have been reviewed by Lee (2012) in her analysis of ‘public health ethics theory’, in which she analyzes thirteen ethics frameworks in public health “selected due to their prominence in the field, impact on the development of other theories, or novelty in approach” (p. 87). In her review, the uniqueness of the focus on justice found in public health ethics frameworks is highlighted: “the focus of justice in clinical medicine is usually faint and on distributive justice, or ensuring that there is enough for everyone entitled to care”, whereas “[i]n public health practice, the focus on justice emphasizes social justice, or rights to health care, and disparities in access and outcomes” (p. 85). While it seems there are some affinities between Lee’s analysis and Kenny and colleagues’ framing of social justice as being ‘relational’ and distinct from ‘distributive’ justice, Lee’s inclusion of ‘disparities in outcomes’ as a feature that distinguishes ‘social’ justice from ‘distributive’ justice illustrates the analytic muddiness of this demarcation.

Lee notes that there is much variation in the terms that are used in public health ethics frameworks that she suggests ultimately “specify similar concepts” (p. 95). She asserts that “what Kass [(2001)] calls ‘social justice’ is similar conceptually to what Childress et al. [(2002)] call ‘distributing burdens and benefits,’ Upshur [(2002)] calls ‘nondiscrimination,’ Thompson et al. [(2006)] call ‘equity,’ Baum et al. [(2007)] call ‘fairness,’ Swain et al. [(2008)] and Jaffe et al. [(2010)] call ‘justice,’ Petrini et al. [(2008)] call ‘equal opportunity for health resources,’ the Nuffield Council [(2007)] calls ‘equality between citizens,’ and Kenny et al. [(2010)] call

‘relational solidarity’” (p. 95). Yet, as the introduction of this chapter argues, while these terms might indeed occupy similar conceptual space, it should not necessarily be presumed that these terms entail the same normative considerations or prescriptions. Indeed, ‘equity’, ‘fairness’, ‘justice’, ‘relational solidarity’, and ‘nondiscrimination’ may each in fact require something unique both in general and in the context of public health. Certainly, the provision of ‘equal opportunities for health resources’, a ‘fair distribution of burdens and benefits’, and realizing ‘equality between citizens’ can each have profoundly different implications for public health policy and practice and for the public’s health. Recalling the discussion in the first half of this chapter, a focus on the distributive character of public health, as in the ‘fair’ distribution of benefits and burdens, attends to a distinct set of considerations as compared to a focus on equality of status among citizens (i.e., one is guided by a distributive principle and the other a relational principle). These terms and their normative considerations or demands cannot be taken for granted and be assumed to cohere within a catch-all value like ‘social justice’. As such, it would be disingenuous to declare that there is agreement about the meaning, scope, and role of social justice in public health in this theoretical literature simply because most public health ethics scholars proffer some justice-based value or principle in their ethics frameworks, especially when those values or principles ostensibly conflict in their dictates.

A curious feature of this theoretical literature worth highlighting is the simultaneously descriptive and normative nature of many of the claims made therein, like the one that ‘social justice is the foundation of public health’. As some have pointed out, the apparent descriptive character of such statements may not actually reflect the ‘reality’ of public health. Indeed, some authors claim that the requirements of justice to a long-term pledge to the public’s health and the needs of the least well off is lacking in public health (Gostin & Powers, 2006). In fact, this was acknowledged by Beauchamp (1976) four decades ago when he said that “the egalitarian and

social justice implications of the public health vision are either still not widely recognized or are conveniently ignored” (p. 6). Yet, these descriptive claims have not been directly empirically explored (let alone substantiated).

There may in fact be reasons to be skeptical that such claims would be substantiated if empirically explored. Indeed, some claim that the ‘social justice approach’ to public health often espoused in the literature might actually run counter to widely held principles of justice based on concepts of moral desert (Buchanan, 2008), the injunction to maximize collective health outcomes (Faden & Shebaya, 2015), or libertarian ideals (Beauchamp, 1976).<sup>11</sup> Indeed, discussions of social justice as the foundation of public health could, and often do, appeal to a multitude of different values or theoretical commitments, including communitarian (Ataguba & Mooney, 2011; Jennings, 2009) or liberal values (Powers, Faden, & Saghai, 2012; Radoilska, 2009), Rawlsian justice as fairness (Daniels, 2001), or human rights (Mann, 1997; Nixon & Forman, 2008; VanderPlaat & Teles, 2005), to name just a few examples. Also worth noting is the noticeable absence of many of the elements discussed in the first half of this chapter from the theoretical discourse of social justice in the context of public health. It is unclear whether these elements, such as the role of desert and the extent to which justice requires a reference to local context, are largely neglected due to their perceived irrelevance to the public health context or whether they simply have not been robustly considered. Thus, despite some degree of consensus in the literature regarding public health’s ‘commitment to social justice’ or commitment to a ‘social justice approach’, it is unclear whether this actually reflects the ‘reality’ or ‘goings-on’ of

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<sup>11</sup> However, to the last point, Faden and Powers (2008) assert that libertarian theories have “limited influence in public health circles throughout the world” (p. 151).

public health, and it remains contested as to exactly which normative considerations these ought to entail.

Two additional themes seem to dominate the conceptual and theoretical discourse of social justice in the context of public health beyond that which is described above: (1) utilitarianism and (2) health equity and health inequalities. Something will be said about each of these themes in virtue of their centrality to social justice discourses in this literature.

### *2.3.1 Utilitarianism*

Utilitarianism has been described as “the main competitor among theoretical alternatives discussed among public health theorists” (Faden & Powers, 2008, p. 151). Indeed, beyond the refrain that ‘social justice is the foundation of public health’, discussions of utilitarianism abound in the public health literature (Bellefleur & Keeling, 2016).<sup>12</sup> For instance, it is not uncommon for authors in this literature to suggest that “public health has strong roots in utilitarianism because of its fundamental focus on collective health” (Nixon & Forman, 2008), “[p]ublic health has long been associated with the utilitarian school of moral philosophy” (Buchanan, 2008, p. 17), “the utilitarian analysis of consequences has, and will continue to have, a central role in public health practice” (Roberts & Reich, 2002, p. 1056), or that “utilitarianism is very much alive in the real world, and nowhere more kicking than in public health and health policy” (Venkatapuram, 2011, p. 26). Some suggest the moral justification for public health is predominantly utilitarian, or at least consequentialist, in nature, due to its concern with the health outcomes of the public as the primary source of measuring success (Childress et al., 2002; Nixon

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<sup>12</sup> Similar to the treatment of social justice in the public health literature, invocations of the term ‘utilitarianism’ are often unaccompanied by robust definitions, and the immense theoretical variation in conceptions and forms of utilitarianism is rarely acknowledged.

et al., 2005). Others simply suggest that public health seems ‘intuitively’ utilitarian insofar as it can be characterized as being concerned with achieving the greatest health benefits for the greatest number within its population (Faden & Shebaya, 2015; Kotalik, 2006).

Utilitarianism refers to a set of theories that, for the most part, propose that the right course of action is that which tends to maximize the greatest utility for the greatest number (Sinnott-Armstrong, 2015). It is the paradigm case of consequentialism (yet the two should not necessarily be considered synonymous),<sup>13</sup> where *outcomes* are considered to be the only factor of moral relevance. Which outcomes are valued, and thus, which outcomes are measured (e.g., pleasure, happiness, preference satisfaction, well-being), distinguishes many forms of utilitarianism (Bellefleur & Keeling, 2016; Lyons, 1965). In its most basic form, utilitarianism as a conception of justice establishes that individuals have claims of justice based on (rule) utilitarian grounds (Harsanyi, 1985). As such, a society (or social institutions) may be considered just when it is arranged so as to achieve the greatest net balance of utility for all individuals (again, depending precisely on how it is formulated) (Mill, 1962 (1861)).

While not referencing utilitarianism by name, Edwards and Davison (2008) argue that “some distancing from public health’s social justice values” (p. 130) occurred following a mid-20<sup>th</sup> century shift towards reductionist thinking and an increased demand for empirical evidence to back public health interventions. To some, the use (and, often, reliance) on cost-effectiveness analyses or expert-determined indices of health status in public health, such as quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs), represents a utilitarian approach to producing the greatest amount of health for the greatest number of people (Jonsen, 1986;

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<sup>13</sup> Although, some suggest that all consequentialism is utilitarian, and that the term ‘consequentialism’ simply refers to non-classical forms of utilitarianism (Sinnott-Armstrong, 2015).

Kotalik, 2006). Indeed, many consider utilitarianism to be one of the leading frameworks for contemporary health policy and welfare economics (Ruger, 2010; Weinstein, 1990; Weinstein & Stason, 1977). Though, despite the ubiquity of utilitarianism in the public health discourse, it is far less common to find an unabashed defense or justification of a ‘utilitarian approach’ in this literature as is found with the ‘social justice approach’.

Interestingly, the link between utilitarianism and public health appears to be amplified in discussions concerning the particular context of public health emergency preparedness and response. For instance, Kirkwood (2010) suggests “there must be an ‘escalator clause’ in the utilitarian aspect [of resource allocation] that suggests that in the event of an extensive threat to the existence of a population, the force of this utilitarian aspect becomes the primary consideration in proportion to the threat...the greater the threat, the greater the moral force of utilitarianism in making public health decisions” (pp. 1-2). As another example, Veatch (2005) asks whether, in public health emergency preparedness and response, we should “retreat to the utilitarian ethic, making an exception to the ethic of justice [sic] that generally prevails in American ethics” (pp. 240-241).

Kotalik’s (2005, 2006) analysis of pandemic plans further raises questions as to whether public health’s ‘utilitarian roots’ become more dominant (or evident) in the context of public health emergencies due to the supposed overarching goals of public health emergency preparedness and response to minimize overall morbidity and mortality and because individual rights in public health emergencies are thought to be contingent upon social arrangements that maximize social utility. Similarly, while lacking empirical substantiation, some authors hypothesize that, in disaster situations or generally resource poor environments, the focus of medical care and public health shifts from the needs of the individual to the needs of the population, and that the traditional bioethics focus on patient autonomy shifts to a utilitarian

model attempting to do the greatest good for the greatest number (Hick & O'Laughlin, 2006; Hick, Robinson, O'Laughlin, & Farmer, 2007).

This raises important questions as to whether distinct contexts or programmatic areas of public health, like public health emergency preparedness and response, perhaps *ought* to operate with distinct conceptions of justice, or whether the ‘social justice approach’ is interpreted differently or has been abandoned altogether in particular contexts or programmatic areas. Jennings (2008), while asserting that one of the ethical goals of public health emergency preparedness and response should be to promote social justice, notes that far less explicit attention has been paid to the ethical and social values and beliefs that are involved in public health emergency preparedness and response, and subsequently calls for the goal of ‘promoting social justice’ in public health emergency preparedness and response to be more clearly articulated and understood. In fact, due to the (ostensible) lack of social justice values and ideals in pandemic plans, an international panel of experts met in 2006 in order to develop a statement of principles that would encourage policy-makers to consider the interests of the disadvantaged as an essential component of pandemic planning (Bellagio Group, 2006a, 2006b).

One possible reason for the (ostensible) inattention to social justice in the context of public health emergency preparedness and response is that considerations of justice, and indeed, achieving justice, may be more challenging (or perceived to be more challenging) during a public health emergency. (Note: while ‘disaster’ is used in the following passage, it does not appear that it is meant to be distinguished from ‘public health emergency’, as this passage is extracted from a US Centers for Disease Control and Prevention document titled *Ethical Guidance for Public Health Emergency Preparedness and Response*.):

Even under the best of conditions, thinking about the nature and demands of justice is difficult and contentious...Even beyond the usual problems posed by the essentially contested nature of philosophical argument, there is ample reason to worry that thinking about justice in the context of disaster planning and response will face particularly vexing obstacles...First, some might argue that thinking about just responses to disasters is pointless precisely because disasters, by their very nature, tend to overwhelm a society's capacity for rational thought and planning...In the fog of chaos, one might argue, thinking about justice is a distracting waste of time; the best we can do is rely on ad hoc, seat-of-the-pants judgments and muddle through as best we can. (Jennings & Arras, 2008, p. 58)

Of course, this idea is merely hypothetical; it is unknown whether this in fact reflects decision-making in the context of public health emergency preparedness and response.

A tension between public health's 'social justice approach' and 'utilitarian aims' is sometimes explicitly acknowledged—for instance, when Faden and Powers (2008) assert that “[c]onsiderations of justice, and not utilitarian aims, are most foundational to public health” (p. 151).<sup>14</sup> Yet, if the two paradigms are in conflict it is unclear how public health's simultaneous 'commitment to social justice' and 'broadly utilitarian aims' are to be reconciled. It may be that utilitarian considerations or aims are not entirely contradicted by whatever it is that is entailed in the 'social justice approach'. This is certainly plausible in virtue of the ambiguous contents of this approach. It may also be that public health's 'utilitarian aims' are mere consequentialist concerns that need not conflict with a 'social justice approach'. Finally, it may be that different justice-based considerations and aims obtain (or are predominant) in different public health contexts, as indicated by the example of public health emergency preparedness and response, which could be responsible for competing perceptions about the justice-based aims of public health.

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<sup>14</sup> These sorts of statements presume that utilitarian aims, or 'utilitarianism', and social justice are mutually exclusive. Yet, this may not be the case. Mill, for instance, argued that his principle of utility (in his theory of utilitarianism) is “the highest abstract standard of social and distributive justice” (Mill, 1962 (1861), p. 318).

### *2.3.2 Health equity and health inequalities*

A discussion of social justice in the context of public health would be incomplete without discussing ‘health equity’ and how it might relate to the concept and role of social justice in this context.<sup>15</sup> Indeed, health equity is increasingly identified as a principal goal to be achieved through public health policies and activities (American Public Health Association, 2014; Canadian Public Health Association, 2014; Public Health Agency of Canada, 2008; World Health Organization, 2014), and is often identified as a core value alongside social justice. For instance, the Public Health Agency of Canada (2008) states that “[i]mportant values in public health include a commitment to equity, social justice...” (p. 3). As mentioned in the introduction of this chapter, this should raise questions (if not concerns) about whether these terms are being treated as synonyms or whether distinct meanings are in fact intended.

The Oxford English Dictionary (2014) has two entries for ‘equity’: (1) “The quality of being equal or fair; fairness, impartiality; even-handed dealing;” (2) “What is fair and right; something that is fair and right.” Of course, the meaning of any of these terms—equal, fair, right—particularly when applied to something like health, is not self-evident. Moreover, if ‘equity’ is to be considered synonymous with ‘fairness’, ‘equal’ or even ‘rightness’, then defining ‘equity’ by reference to these terms will tend to be circular. And while dictionary definitions are quite obviously not the final arbiter when it comes to how concepts are, or ought to be, understood and invoked in practice, it is at least instructive that ‘equity’ might generally be used interchangeably with terms like ‘fairness’, ‘impartiality’, ‘equality’ ‘right’, and indeed,

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<sup>15</sup> Much of this section was recently published in Smith (2015). See copyright acknowledgements at the end of this thesis.

‘justice’, in everyday discourse. At the very least, such definitions provide us with information about other proximal moral values that may be imbued by the concept.

Equity takes on a more specific meaning in the philosophical literature (Asada, 2007). In this literature equity is considered one of the material principles of justice, and is commonly understood to exist when justice judgments reflect the ratio of one’s contribution to one’s receipts; justice exists when this ratio is equal for all individuals (Miller, 2001). This is similar to ‘equity theory’ as developed in the social sciences, where the structure of equity is based on the ratio of inputs to outcomes (Adams, 1965). ‘Pay equity’, which requires employers to pay individuals of different genders similarly if their jobs are of comparable value (i.e., equal ratio of inputs to outputs), is a straightforward example of how this principle manifests. Of course, equity, as it concerns equal ratios, may in fact require one’s receipts to be proportionate not to contribution (e.g., job performance), but perhaps rather to entitlement, merit, or some other desert-based input. However, it seems that desert, whatever its form, is an unlikely referent to which *health* equity commonly applies in virtue of the apparent ill-suited relationship between health and desert (Outka, 1974). Instead, it could be that *health* equity refers to the ratio of one’s receipts to one’s *health* (or in other words, *health needs*). Interpreted in this way, the principle of equity becomes similar if not indistinguishable from the material principle of need.

Curiously, however, the field of public health has largely defined and understood health equity in a somewhat unique manner. The definition most cited and promulgated in the public health literature is that which was developed by Whitehead (1992), who stated that health inequities are “[health] differences which are unnecessary and avoidable but, in addition, are considered unfair and unjust” (p. 433). Whitehead’s definition suggests that what is of

importance for health inequity is health inequalities—that is, ‘differences in health’.<sup>16</sup> However, instead of treating all differences in health as inequities, Whitehead asserts that health inequities are only those differences in health that are (a) unnecessary, (b) avoidable, and considered to be (c) unfair and (d) unjust. Whitehead’s use of language can be instructive. For instance, she asserts that differences in health that *are* unnecessary and avoidable and those that *are considered to be* unfair and unjust ought to be considered candidates as inequities. We could perhaps assume, then, that on this conception, health differences that are unnecessary and avoidable are thought to be knowable irrespective of our judgments, but that health differences that are unfair and unjust require information about our judgments.

What is *considered* to be unfair and unjust,<sup>17</sup> and in particular what is considered to be unfair and unjust with respect to differences in health, is an empirical question to which reasonable people will likely disagree. To populate this component of Whitehead’s definition with actual guidance regarding which health differences are ‘considered unfair and unjust’, we would need to explore people’s perspectives on what is unfair and unjust—indeed, this is an aim of this study. We could also refer to the theoretical literature described in this chapter to account for the myriad positions about which differences in health ought to be treated as unfair and unjust (Braveman & Gruskin, 2003; Hausman, 2007; Hausman, Asada, & Hedermann, 2002; Wilson, 2011). At any rate, this condition of Whitehead’s definition requires specification of what

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<sup>16</sup> This analysis leaves to one side the normative dimensions that may be tacit in any invocation of the word ‘health’. Defining a concept of health is “a process that involves value judgments and...is potentially subject to political contestation” (Peter, 2001, p. 97). And, as Daniels (2011) argues, the “characterization of health has implications for what counts as pursuing equity in health” (p. 192). Due to the expansive literature that has dealt with the normative dimensions of health, it will suffice here to simply acknowledge that what constitutes ‘unnecessary’, ‘avoidable’, ‘unfair’, and ‘unjust’ differences in *health* will inevitably depend also on how one defines health.

<sup>17</sup> As others (e.g., Wilson (2011)) point out, it is not clear why Whitehead makes reference to differences in health that are both ‘unfair’ *and* ‘unjust’, nor what she intends the difference between the two terms to be.

constitutes, or at least what are *considered* to constitute, unfair and unjust differences in health. Unfortunately, the definition provides no information about which account(s) of justice is (or are) meant to be used to make this determination. This may reflect Trotter's (2008) previously referenced critique that it is "simply presumed that everyone working in public health already knows what justice is" (p. 457).

Let me then return to the idea of 'unnecessary' and 'avoidable' differences in health to determine whether these conditions allow us to side-step the indeterminacy of what it is that is meant to be considered unfair and unjust differences in health. It may at first seem unhelpful to include the conditions of 'unnecessary' and 'avoidable' differences in health alongside 'unjust' differences in health in a conception of health equity. As Wilson (2011) argues in his critique of Whitehead's definition, if we already considered differences in health to be unjust, "I do not think that being also told that the inequality was 'unnecessary and avoidable' would add anything" (p. 215). Others have similarly recommended dropping 'avoidability' as a criterion from Whitehead's definition, claiming that 'unjust' and 'unfair' imply avoidability (Braveman & Gruskin, 2003). Wilson and others therefore argue that the only criteria of Whitehead's definition that remains standing is the idea of unjust differences in health (Braveman & Gruskin, 2003; Braveman et al., 2011; Kawachi, Subramanian, & Almeida-Filho, 2002; Wilson, 2011). Recall, though, that Whitehead defines health inequities as those differences in health that are unnecessary and avoidable "but, *in addition*, are considered unfair and unjust" (Whitehead, 1992, pp. 433, my emphasis). This means that if we consider a difference in health to be inequitable because it is unjust, we know that it must also be unnecessary and avoidable, as per Wilson's argument. However, if we do not know or are unsure as to whether a difference in health is unjust (or are not provided the criteria to make such a determination, as with Whitehead's

definition), then it may still prove helpful to determine which differences in health are unnecessary and avoidable in order to circumscribe those that require additional moral scrutiny.

Ultimately, differences in health that are considered ‘unnecessary’ or ‘avoidable’ will be dynamic and dependent on perceived (or real) resource constraints, epistemological limitations, and the social, political, and economic context in which those considerations exist (Smith, 2015). However, in Whitehead’s definition the conditions of ‘unnecessary and avoidable’ serve as seemingly value-neutral counterparts to the explicitly value-laden criteria of ‘unfair and unjust’, even though the former may ultimately rely on similar normative considerations to those involved in the latter. This conclusion is only further supported by the earlier point that this definition suggests that health inequities involve differences in health that *are* unnecessary and avoidable and *are considered to be* unfair and unjust. Ultimately, which health differences that are ‘unnecessary’ and ‘avoidable’ will be imbued with values about what we consider to be of greater or lesser necessity, beyond our control or not feasible to control, and what is fair and just, and will therefore require normative assessment and specification.

What this ultimately suggests is one of two things: either what constitutes ‘unnecessary’ and ‘avoidable’ differences in health collapses into judgments about what constitutes ‘unjust’ differences in health (and thus ‘health equity’ in this form is entirely reliant on a more foundational conception of justice), or what constitutes ‘unnecessary’ and ‘avoidable’ differences in health are at least imbued with tacit values, some of which ultimately being derivative of a conception of justice. In the former case, ‘health equity’ can be considered synonymous with health justice, but does little if nothing to specify the normative features of

such an account of justice.<sup>18</sup> Considering that many non-philosophers likely treat equity and justice as synonyms, this definition of health equity might very well be circular, providing very little conceptual or practical clarity for the practice of public health (i.e., health inequities are unjust inequalities, and what is ‘unjust’ is synonymous with what is inequitable). In either case, ‘health equity’ can be considered at least partly dependent on a more robust conception of justice to do some of its normative work, and thus more specification of a conception of justice (whether it be drawn from philosophy or from empirical research that engages relevant stakeholders—or both) is required in order to provide normative guidance for public health policy and practice.

With that said, in an attempt not to label *all* differences in health as morally wrong or unjust, those in public health have typically treated *equality* as a wholly descriptive concept with little consideration of its normative dimensions, while treating equity as a (mostly) normative concept (Kawachi et al., 2002; Wilson, 2011).<sup>19</sup> Sometimes this is made explicit; for example, when Braveman and Gruskin (2003) assert that the “concept of equity is inherently normative—that is, value based, while equality is not necessarily so” (p. 255).

The use of ‘health inequities’ to refer to morally significant health inequalities is of course not inherently problematic and could merely reflect a difference in institutional or disciplinary vernacular. However, three possible issues emerge in this shying away from a

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<sup>18</sup> As such, the public health professional may have to seek out and independently evaluate the myriad interpretations of health equity and/or justice proffered by others in the scholarly literature. For instance, Braveman and Gruskin (2003) argue that “equity in health ought to be considered the absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/disadvantage”, and that this supports operationalizing “the right to the highest attainable standard of health as indicated by the health status of the most socially advantaged group” (p. 254). Accounts such as Braveman and Gruskin’s are helpful, but given that no consensus interpretation or account has been developed, this may only take us part of the way in resolving the issue of health equity’s indeterminate nature as it is used in practice.

<sup>19</sup> For example, the Public Health Agency of Canada (2010) makes the following claim: “Equity in health is not the same as equality in health status. Inequalities in health status between individuals and populations are inevitable consequences of genetic differences and various social and economic conditions, or a result of personal lifestyle choices.”

normative conception of health equality in public health. First, health equality—however defined—may actually be preferred, or indeed may be preferable, in public health (or at least some domains of public health), but may be rejected in favour of ‘health equity’ due to the insistence that “equity is not the same as equality” (Braveman & Gruskin, 2003, p. 255). While equity and equality could be conceptually distinguished (as was illustrated in the previous discussion of the common philosophical treatment of equity as a distinct material principle of justice), such a statement seems to suggest that our goal ought to be *equity* and not *equality*, and that the latter may not be a worthy moral pursuit of public health. The notion that health equality is not a desirable goal in public health should not be taken for granted, as some do indeed argue that *all* inequalities in health should be considered unjust and that, as a result, our goal with health equity ought to be to get as close as is feasible to equal health (Culyer & Wagstaff, 1993; Veatch, 1981). If this is also the intuition of those working in public health, then it is unclear how they should be expected to respond to the claim that it is “obvious...that equity differs from equality” (Chang, 2002, p. 488).

Second, framing health inequities as normative and health inequalities as descriptive may have significant implications for practice, particularly when research, policy, or practice make no mention of health ‘inequities’ and only discuss or pursue the aim of a ‘reduction in health inequalities’. By speaking only to the ‘reduction of health inequalities’, this work may *purposefully* proceed without explicit normative analysis or making explicit the prescriptive standard that is being applied. Without an explicit linkage to health equity (or social justice), it may be that the normative features or underpinnings of the ‘reduction of health inequalities’ are overlooked, concealed, or considered to be out of scope, as such a strategy does not specifically invoke ‘inequities’ (Asada, 2007; Harper et al., 2010). This is evident, for instance, in a recent publication that frames its topic as ‘monitoring health determinants with an equity focus’, which

only discusses health inequalities with no analysis or description of how or in what ways they relate to an ‘equity focus’ (Pedrana, Pamponet, Walker, Costa, & Rasella, 2016).

Third, it would be unfortunate if the significant philosophical scholarship regarding the concept of equality were to be disregarded as a normative guide for public health. Many insights could come from engaging with the scholarly work that investigates the nature and role of equality in moral and political philosophy. For example, Whitehead’s definition of health inequities begins by targeting ‘differences in health’ (of a certain kind) as eligible health inequities. That is, on this interpretation, health inequity has a requirement of there being an inequality in health. However, this renders ineligible any assessment of ‘similarities in health’, or health *equalities*, as morally important to address (what might be considered ‘unjust equalities’ in the egalitarian literature) (Segall, 2009). Discussions of health equity beyond Whitehead continue to interpret health inequities as the presence of unjust differences in health without considering the role of unjust equalities (e.g., see Braveman and Gruskin (2003)). Indeed, equality of health status between populations could still be considered unjust on a procedural or relational account of justice.

Despite these issues of indetermination, the role and reach of health equity in public health appears to be expanding. Due to the powerful impact that social conditions have on health, an effort has been made to introduce health assessments in public policy outside the domain of health (i.e., outside the domain of public health and health policy). ‘Healthy public policy’ or ‘health in all policies’, as it is sometimes called, is meant to better ensure that public policy in sectors other than health (e.g., transportation, education) carefully evaluates potential impacts to population health (Kickbusch, 2010; Mittlemark, 2001; National Collaborating Centres for Healthy Public Policy, 2008; Ståhl, Wismar, Ollila, Lahtinen, & Leppo, 2006). Given public health’s interest in health equity, it is not surprising that there are those who have

correspondingly advocated for ‘health equity in all policies’ (Marmot & Allen, 2014) and the inclusion of ‘health equity impact assessments’—a tool meant to identify population subgroups that may bear a disproportionate health impact from both health and non-health related public policy—in this approach (Povall, Haigh, Abrahams, & Scott-Samuel, 2014; Snyder et al., 2012; World Health Organization, 1997).

There is little doubt that health ought to figure prominently in the overall assessment of public policy, but it is disputable whether *health equity* ought to have its own special status, particularly in the assessment of equity in public policies outside the domain of health. In other words, it is unclear why one ought to be concerned with *health equity* in non-health public policy rather than a broader conception of *social equity* (read: social justice) that accounts for values in addition to health. Even if health equity ought to have special status in the assessment of equity in public policies outside the domain of health, the degree to which it should be weighted against the achievement of equity for other social goods is unclear (Weinstock, 2011, 2015b). These challenges reflect a persistent philosophical debate regarding the putative special moral importance of health to justice (Daniels, 1985, 2007; Segall, 2008; Wilson, 2009a). Emerging areas of practice in public health that enable or encourage policy-makers and practitioners to treat *health equity* as special—health equity impact assessments, healthy public policy, and ‘health equity in all policies’—have all but neglected these important questions, which may perhaps be a symptom of health equity’s underspecified nature when used in practice and the considerable normative assumptions that must be made by policy-makers and practitioners when pursuing health equity.

As Daniels (2011) has argued, we live in societies that tolerate and even encourage some significant degree of inequality (e.g., ‘just deserts’). These inequalities may occur in domains that, in turn, determine health status (and thus may create health inequalities). If we accept as

otherwise just some of the inequalities we allow in our society, but these inequalities contribute to morally significant health inequalities, then it is unclear whether we ought to view those health inequalities as themselves just or, rather, re-evaluate whether we ought to consider as unjust the initial inequalities that we allow in our society.<sup>20</sup> In public health, one must consider whether equality in the social determinants of health is being sought for its instrumental value for health and health equity or whether equality in the social determinants of health has intrinsic value and thus ought to be pursued irrespective of its impact on health equity. If one is more inclined to affirm the latter, then perhaps using a ‘health equity’ lens comprised of health indicator measurements alone should be scrapped in favour of the more comprehensive goal of social justice that seeks to redress broader social inequalities, which would likely involve entirely different metrics and interventions (Hausman, 2007). Indeed, if this is to be the case, then as Wilson (2009a) argues, “we cannot talk about a theory of justice for health [or, health equity] in isolation from an overall theory of justice” (p. 3).

It is therefore clear that considerations of justice must play a fundamental role in shaping the tacit normative commitments entailed by the pursuit of health equity in public health. This is evident not only due to the explicit consideration of justice in Whitehead’s influential definition of health equity, but also the fact that tacit judgments about justice must be made regarding what constitute ‘unnecessary’ and ‘avoidable’ differences in health. And while it is apparent that health equity relies, at least in part, on a more foundational conception of justice to do its normative work, it is unclear exactly what that conception of justice entails, or ought to entail, in

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<sup>20</sup> Even if equality in the social determinants tends to produce equality in health, there are more than likely cases where this is not the case. Moreover, despite potential convergence between the aim of achieving equality in the social determinants of health and achieving equality in health outcomes, different strategies for measuring and, ultimately, achieving those aims might exist depending on which aim is to be pursued.

the pursuit of health equity. As such, it seems that any discussion of health equity necessitates an engagement with justice.

### *2.3.3 Powers and Faden's Twin Aim Theory*

As illustrated in the foregoing pages, there are innumerable possible elements and forms of social justice. In recent years, attention has increasingly been paid in particular to the integration of health with traditional concerns of justice. These concerns have largely focused on access to health care and medicine and setting priorities for health care funding and delivery (Faden & Powers, 2008; Powers & Faden, 2006). Among the emerging literature integrating concerns of justice with health, Powers and Faden's (2006) Twin Aim Theory should be considered unique and most relevant to this study for at least two reasons. First, their theory is 'non-ideal', which means it attempts to provide a "loose framework for deliberation" (p. xi) aimed at capturing what is fundamentally at stake in assessing issues of justice in concrete, 'real-world' settings. This can be contrasted with 'ideal' theories of justice, which seek to identify and develop the principles, considerations, and background conditions sufficient for a fully just society (Rawls, 1999). Given that this study is primarily concerned with understanding social justice in the 'real-world' setting of public health policy and practice, I expect that a theory addressing 'real-world' considerations and settings provides, or at least ought to provide, a more relevant theoretical discussion of the justice-based considerations that might be reflected in the perspectives of those practicing in the 'real-world' context of public health.

Second, Powers and Faden's Twin Aim Theory arguably constitutes the only normative theory of justice developed "out of an original concern with questions of justice in public health" (p. 80). The authors state that, "[i]nsofar as bioethics has concerned itself with justice and health policy, the focus has been almost exclusively on access to medical care and the allocation of

medical services” (p. x), which has “concentrated on inequalities in health and access to health care, and on questions about how priorities should be set when resources are scarce” (p. 3).

Powers and Faden argue that “[i]t is impossible to make progress in our understanding of the demands of justice within medical care without looking outside of medical care to public health and to the other determinants of inequalities in health and indeed without situating an analysis of justice and health policy in the wider social and political context” (p. x). Indeed, the authors contend that their “theory of justice offers a moral foundation for the theory and practice of public health” (Faden & Powers, 2008, p. 156), and that it “provides a fine, if not perfect, fit with the commitments and practice of public health” (Powers & Faden, 2006, p. 80). To my knowledge, no other theory of justice makes similar claims about its intended fit with the actual commitments and practice of public health. It should be noted that I am not suggesting the Twin Aim Theory actually provides a fit with the commitments and practices of public health, nor that it provides a superior fit compared to other theories. Rather, my claim is merely that no other theory explicitly presents its scope in quite this manner. Indeed, part of what this study is poised to explore is the fit between the ‘commitments and practices of public health’ and theories of justice by generating information about public health policy-makers’ perspectives, and analyzing the extent to which those perspectives align with philosophical discourses. As such, Powers and Faden’s Twin Aim Theory will constitute a focal point of the interpretative framework for this study. With that said, the myriad other theoretical and analytic considerations described above will act to supplement the Twin Aim Theory in order to ensure the interpretative framework remains sensitized to other considerations of justice, particularly those not captured or addressed by the Twin Aim Theory.

According to Powers and Faden's Twin Aim Theory,<sup>21</sup> social justice has two distinctive aims (i.e., the 'twin aims'): one focused on outcomes and the other on what they call fairness. This dual focus reflects Powers and Faden's thesis that both outcomes and fairness are normatively distinct concerns of justice, meaning that neither aim alone should be considered adequate for a theory of just social arrangements.

The first aim of justice, which Powers and Faden call the 'Basic Well-being Aim', requires social arrangements to secure six core elements of well-being characteristic of a decent human life. These six core elements are health, cognition, personal security, personal attachment, respect of others, and self-determination. According to this aim, well-being is a condition or state of affairs that is good for someone to be in; a deprivation in well-being exists where one is outside the range of what is required for a decent human life. As such, justice according to the Twin Aim Theory demands that everyone receive a sufficient amount of each of the essential dimensions of well-being, including health. This positive aim is outcome-oriented and can be considered to be in the theoretical space of sufficientarianism.

The second aim of justice, which Powers and Faden call the 'Structural Fairness Aim', requires that social arrangements combat serious forms of systematic disadvantage that act as social impediments to the realization of a minimum level of well-being. This second aim can be considered to be in the theoretical space of equal opportunity theories of justice. Thus, while the Basic Well-being Aim seeks to combat deprivations in each element of well-being, the Structural Fairness Aim seeks to locate injustice in the structural unfairness of social arrangements that

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<sup>21</sup> Some of the terms I use in the description of this theory were derived from personal communications with Madison Powers in 2015, and therefore reflect an evolution of the terminology used to describe the theory since it was first published in 2006. Thus, my description may not entirely reflect the terminology present in the original publication of the theory (e.g., 'Twin Aim Theory'; 'Basic Well-being Aim'; 'Structural Fairness Aim'). With that said, the substantive features of the theory remain faithful to that which was originally published.

distribute advantages and disadvantages in certain ways. The Structural Fairness Aim therefore ensures that the Twin Aim Theory of justice has something to say about individuals' realistic chances of improvement in life prospects even when they do not actually fall below a sufficiency of well-being. It also allows the theory to say something about the moral salience of inequalities in well-being, even when the well-being in question exists above a level of sufficiency; namely, the moral significance of inequalities depends on how they interact with others to reinforce disadvantage. This negative aim of justice therefore demands constant vigilance against patterns of systematic disadvantage that undermine prospects for well-being, and imposes the obligation to ensure that public health policies prevent, and do not exacerbate, such patterns.

Powers and Faden's Twin Aim Theory is rather unique in its focus on well-being. Ultimately, the authors argue that the object of justice is successful *functioning* in the six dimensions of well-being—the actual achievement of functionings—and not simply the individual's opportunity or capability to achieve functionings, as is argued (variably) by other justice scholars like Daniels (2007), Sen (2009), Nussbaum (2000), Ruger (2010), and Venkatapuram (2011), for example. While capability approaches often interpret capabilities in terms of what individuals are able *to do and be*, Powers and Faden's theory concerns itself with the *achievement* of states of *being* well-nourished, *being* educated, *being* healthy, or *doing* certain activities, like voting in elections.<sup>22</sup> Powers and Faden argue that, while health can in some ways be described in functionalist terms, it is more preferable to describe things like health as 'desirable states' of well-being. In essence, though, their theory largely consists of the same elements of capability approaches, but they simply decide to note that "there are distinct

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<sup>22</sup> Venkatapuram (2011), by contrast, argues for an account of justice where every human being has a moral entitlement to a *capability* to be healthy and not directly to certain health outcomes or biological and mental functionings.

dimensions of well-being and that, for each dimension, a part of its value lies in what states are achieved and another part often consists in our active role in bringing states about” (Powers & Faden, 2006, p. 38).

Given the theory’s focus on several elements of well-being, it is important to note that the Twin Aim Theory rejects the ‘separate spheres’ view of justice. Rather, Powers and Faden argue that their theory starts with the defeasible presumption that all six elements of well-being are morally relevant as a matter of justice, and that speaking about justice in public health requires reference to how people are doing with respect to other elements of their well-being or to how other public policies and social environments are structured. That is, justice in health cannot plausibly exist in isolation from larger issues of social justice. This is an approach that contrasts rather starkly from that of Ruger (2010), for example, who argues that “it is unwise to attempt to improve health with broad non-health policies, such as completely flattening socio-economic inequalities”, as doing so tends to “cloud rather than clarify the means and ends of health policy and our ability to evaluate the impact of public policy on health” (p. 6). Ruger, who adopts a separate spheres view of justice, does not necessarily dispute Powers and Faden’s argument as stated above (she recognizes the influence of many policy domains on health), but instead favours avoiding this complexity rather than addressing it directly. For instance, in citing her reasoning for embracing the separate spheres view, Ruger asserts that “we are far from understanding the precise societal mechanisms that influence health or how to weight different social objectives” (p. 6). Yet, uncertainty or conflicting views in these areas, while certainly presenting a challenge for policy and practice, should not altogether preclude their consideration in a conception of social justice for public health. Indeed, eschewing questions that concern how different social goods or objectives ought to be weighted within an account of social justice may tend to artificially direct our attention away from the just means and ends of public health policy

and practice. Bracketing these questions off from consideration will act to constrain our thinking regarding what just means and ends can look like in public health rather than achieve Ruger's stated aim of providing clarity about what those just means and ends truly ought to be.

Ultimately, it seems this approach to thinking about social justice in public health will inevitably be incomplete, as public health activities are in fact pursued in an environment where different social objectives will impact what are considered to be legitimate and just public health means and ends.

Another significant feature of Powers and Faden's Twin Aim Theory is its attention to socially situated groups. Through its Structural Fairness Aim, the Twin Aim Theory incorporates considerations beyond the distributive paradigm and its focus on micro-allocational questions of priority setting and how one individual fares compared to another, to a focus on the well-being of people in social communities or groups, the nature of relations among people, and social subordination and stigma. As such, the Twin Aim Theory acknowledges that some who fare worse than others are members of groups who are socially situated within densely woven patterns of disadvantage.

In practice, the specific job of justice for the Twin Aim Theory is to "attend to all those aspects of the social structure that exert a profound and pervasive effect on the development of each of the essential dimensions of human well-being, separately and in combination under actual social conditions" (p. 31). The goal, then, is "attending first to the needs of those whose absolute well-being is below some level of sufficiency, while at the same time explaining when, and which, residual inequalities, including relative inequalities in the various social determinants of well-being, are unjust" (p. 57).

Powers and Faden acknowledge that,

...even if an overall system for social provision of public health or health care resources passes the test of justice, many distributive questions remain unresolved. Because our theory is addressed to questions about the design of the basic social structure, the practical guidance our theory provides for the resolution of priority problems is frequently one step removed from the kinds of midlevel and micro-level decisions that public health officials, health plan managers, and clinicians make on a daily basis. (p. 143)

Importantly, then, engagement with public health professionals may provide insight into these midlevel and micro-level considerations of justice, and provide a means of exploring the extent to which these considerations align with a macro-level theory such as the Twin Aim Theory. Indeed, Powers and Faden contend that we should continue to search for better theories of justice that can have practical significance in actual, non-ideal circumstances. By engaging with those who have particular insight into the actual, non-ideal circumstances of public health (e.g., public health professionals), an opportunity exists to improve our understanding and the practical significance of theories of justice.

## **2.4 Conclusion**

This chapter illustrates the extensive variation that the meaning and scope of social justice takes within the theoretical literature. While the variation is attenuated somewhat as it has been discussed in the context of public health, there remain significant differences in how social justice is conceptualized, reflecting much of the variation in the broader philosophical literature, and it is hitherto unknown whether theory in this area has practical significance for those working in public health or whether it reflects or coheres with the ‘goings-on’ of public health. As Powers and Faden assert, arguments about the ‘best’ theory of justice will continue, and there is no doubt that philosophers will continue to develop new accounts that address questions of

justice in the context of public health; however, if social justice theory is to have relevance and significance to public health beyond academia—if it aims to be pragmatic in the slightest—then it ought to confront the experiences and perspectives of those who may not have the capacity or avenue to contribute to this philosophical discourse but who nonetheless have important, context-sensitive insight into social justice as it is conceptualized, negotiated, and pursued in public health policy and practice.

This chapter sought to describe the body of theoretical literature that best frames and contextualizes this study's particular research problem and questions, which in turn forms the basis of a theoretical 'inventory' from which this study's apparatus for data analysis and interpretation was able to draw and evolve. What is absent from this chapter is a spirited defense of any particular conception of social justice (despite a *prima facie* endorsement of Powers and Faden's Twin Aim Theory to serve as a focal point of the interpretative framework for this study). This was deliberate given my agnosticism on the matter, which is in part fueled by my conviction that a proper conception of social justice, if it is to be used in an applied, practice-based context like public health (or, indeed, if it is to constitute the 'moral foundation' or 'core value' of public health), should benefit from an understanding of the perspectives and insights of those tasked with the interpretation, application, and pursuit of the value in this very context.

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## Chapter 3

# Review of relevant empirical research reporting perspectives on social justice in public health policy and practice

*“Although the call for social justice is frequently voiced in public health, it is critically important for the field to address major differences in definitions of justice found among the general public.”*

- David R. Buchanan, 2008

The previous chapter illustrates the polysemous and contested nature of the term ‘social justice’ and highlights the variable manner in which the concept has been theoretically explored and discussed in the public health context. To some degree this variation and complexity should be expected from philosophical and theoretical treatments of this topic. A pertinent question this raises, though, is whether this sort of variation and complexity would similarly be found among the perspectives of those concerned and charged with the interpretation and application of the value in practice.

In reality, we know that public health decisions and activities proceed despite theoretical muddiness and disagreement about this ostensibly foundational value. One wonders whether particular conceptions or considerations of social justice are preferred or predominant among public health professionals, whether disagreements about the proper aims and scope of social justice are resolved, set to one side, or simply avoided in order to make decisions in public health policy and practice, or whether the contents and scope of social justice are considered in public health decision-making at all. These questions are significant given the putative importance of the value of social justice to public health *practice*. That is, inquiring about the proper meaning and *desiderata* of social justice should not be considered a mere intellectual or theoretical exercise given the practical import assigned to the value of social justice for public

health practice (and, indeed, for the public's health). Hence, it is not only important to explore and understand the ways in which theoreticians have sought to advance our understanding of the concept but also how public health professionals interpret, conceptualize, and use this concept in their work. Engaging public health professionals in this way may work to advance our understanding of the concept and provide important insight into how the value can, and should, guide public health activities.

This chapter therefore seeks to explore and situate my study's research problem and questions within the existing body of empirical literature that reports perspectives on the meaning and role of social justice in public health policy and practice. In so doing, I will identify and critically appraise what is 'currently known' (i.e., reported in the literature) with respect to this study's research problem and questions, the hitherto unexplored or unaddressed questions related to this study's research problem, and how and where this study can make a scholarly contribution to this corpus.

### **3.1 Scope of the review**

The literature reviewed in this chapter was retrieved through searches of the US National Library of Medicine MEDLINE database and JSTOR database using a combination of terms related to this study's concept of interest (e.g., 'justice', 'equity', 'fairness'), context of interest (e.g., 'public health'), and methodology of interest (e.g., those capable of generating information about people's perspectives, which meant including terms like 'survey', 'questionnaire', 'interview', and 'focus group'). Ancillary searches of retrieved publications' bibliographies and manual searches of journals deemed of high relevance to the domain of this study (e.g., *Public Health Ethics*, *Social Justice Research*), were also conducted (see Appendix I for a more detailed overview of the search strategy).

The method I employed for establishing the scope of this review was informed by Strech and colleagues' 'MIP model' for empirical literature reviews in bioethics (Strech, Synofzik, & Marckmann, 2008). The MIP model takes into account what they consider to be the "essential aspects" (p. 473) of literature review questions, which, when deployed in a literature search strategy, are meant to "guarantee sensitivity and specificity" (p. 473) in the retrieval of relevant literature: methodology, issues, and participants (MIP). In my review, I assessed the literature's methodologies and issues (although I use the term 'concept of interest' for the latter given my study's interest in exploring perspectives about a concept of interest, not an 'issue' *per se*), but because a relative dearth of literature exists exploring my study's topic, I chose to expand the MIP model's intended focus on a particular profile of 'participants' to a 'context of interest' (i.e., public health policy and practice) that would include multiple profiles of participants (e.g., public health policy-makers, practitioners, etc.).

Despite utilizing a rubric informed by the MIP model, my determination of publications' relevance in this review ultimately remained an interpretive exercise, where any 'guarantees' of sensitivity and specificity in the retrieval of relevant literature were abandoned as unrealistic and undesirable. This accords with the principal objective of this review, which is distinct from systematic reviews: to frame and contextualize my research problem and questions by situating them within an account and critical review of the empirical literature that best establishes this context given the particular nature, scope, and theoretical background of my study. As such, I expect that a study with even slightly different research questions and objectives, even if operating under the same 'review questions' as described in this chapter, would interpret 'relevance' in a slightly different, context-dependent manner. This approach is common in bioethics literature reviews, where the primary aim is to capture key ideas rather than comprehensively identify and analyze all relevant publications (McDougall, 2014).

Nevertheless, more will be said presently about how I interpreted the relevance of publications in order to better establish the scope of this review.

To assess the ‘conceptual’ relevance of publications, the question posed to the literature was whether it explored, studied, or reported perspectives explicitly related to the concept of social justice. In effect, this parameter served as a means to discard publications that were returned from the search solely because the term ‘justice’ was used but was not explored or studied in any way. Many publications make mention of justice in passing, even in abstracts, most notably by claiming that their findings, whatever they might be, ‘have implications for social justice’. Publications such as these tend to do little if nothing to explicate or explore what this means, nor do they report perspectives on social justice. Hence, such publications would not be deemed relevant given the nature and scope of my research problem and questions.

With that said, given the ambiguous, complex, and contested nature, scope, and terminology of ‘social justice’ (see Chapter 2), it is not unreasonable to expect that (a) some publications might use other terms (e.g., equity) to refer to the same concept of interest in this study, or (b) empirical information about people’s perspectives about related concepts, like equity or fairness, even if conceptually distinct from social justice, could tell us something of interest to this study’s objectives and research questions. This undergirds the rationale for including other key justice-related terms in the literature searches (e.g., ‘equity’, ‘fairness’). Other notable justice-related terms, such as ‘equality’ and ‘disparity’, were not included among the justice-related terms in the searches for two reasons.<sup>1</sup> First, a preliminary search including

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<sup>1</sup> The innumerable possible key words to include is a common challenge for bioethics literature reviews. Publications on bioethics topics largely involve a diversity of terms (e.g., see Chapter 2 for the multitude of terms potentially relevant to publications that say something about social justice). This can be sharply contrasted with the specificity of biomedical terminology that can be exploited by, and is perhaps required for, systematic reviews (McDougall, 2014). As such, in bioethics literature reviews such as this one, it is important to include a diversity of terms; however, this has the effect of returning a substantial number of irrelevant publications given how some terms are used in different contexts (e.g., the difference between using ‘equality’ and ‘disparity’ in such a way that

these terms returned far too many publications of epidemiological studies that merely sought to describe health differences between populations and/or individuals, which did not explicitly address their relation to social justice or explore perspectives on the matter. In fact, a recently published bibliometric analysis of research on ‘health inequalities’ found that much of this research uses the terms ‘inequalities’ or ‘disparities’ indiscriminately, without explicitly or necessarily implying the presence of injustice (Bouchard, Albertini, Batista, & Montigny, 2015). Second, in the case that terms like ‘equality’ and ‘disparity’ would be used in the sense relevant for my study, it was expected that one of the other justice-related terms included in my searches would also appear.

Concepts or terms like ‘oppression’, ‘subordination’, ‘disadvantage’, ‘exploitation’, or ‘discrimination’, while *perhaps* having relevance to justice, were not included as specific search terms in my review as it would be unclear whether studies examining these concepts necessarily tell us anything about how social justice is conceptualized in public health policy and practice (without explicitly saying so). The systematic retrieval and analysis of all literature exploring perspectives on potentially related concepts like these *could* provide insight into concepts ostensibly related to justice; however, such a project would constitute a study in and of itself and does not fit within the scope of a *review* of literature that can tell us how perspectives about the concept and role of social justice in public health policy and practice have previously been represented. In all cases, the theoretical background to this study (i.e., Chapter 2) provided a further analytic apparatus of evaluating whether publications took social justice as a concept of interest.

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acknowledges or explores their normative characteristics and relevance to social justice, which is what I am interested in, rather than simply using such terms to refer to ‘differences’, which is more common in epidemiological studies). As such, given the reasons supplied in the main text of this chapter, multiple terms were used, but the terms used were chosen judiciously.

Much like with the term ‘justice’, if publications were retrieved in the initial search because they made passing mention of ‘public health’—e.g., ‘these findings have implications for public health’—but did not directly explore anything directly related to the policy and practice context of public health, they were excluded as they did not pass the relevancy test for the ‘context’ under study. For practical purposes, a foreseeable debate regarding whether publications ‘truly’ focused their attention to the ‘context’ of public health policy and practice and not some other context (e.g., health care) was pre-empted, at least in the initial search, by adopting a broad strategy where any and all literature that simply mentioned ‘public health’ was included. To be sure, many more studies, both theoretical and empirical, have explicitly examined perspectives on justice in the context of medicine and health care (e.g., the allocation of organs for transplantation, setting priorities for scarce health care resources and technologies, and so forth) compared to the context of public health policy and practice (Faden & Powers, 2008). At any rate, the goal of these searches was to be cautiously inclusive rather than exclusive given the contested nature of the ‘context’ of public health, and in order to not neglect potentially relevant literature. As my study is interested in how social justice is conceptualized in the context of public health as it is *practiced*, it is not unreasonable to expect that, irrespective of any ambiguity or disagreement regarding what might constitute the ‘context’ of public health, literature exploring anything in the vicinity of the focal point of my research will at least mention the term ‘public health’. Given the scope of this study (see Chapter 4), literature situated in the Canadian-specific context was considered particularly relevant.

Finally, to assess ‘methodological’ relevance, the question posed to the literature was whether it had an empirical component aimed at interpreting, or generating data about, the perspectives of individuals or organizations. This excludes literature that solely provided its authors’ own ideas, beliefs, comments, experiences, prescriptions, arguments, hypotheses, or anecdotes. Many such publications can be categorized as ‘conceptual’, ‘theoretical’, or

‘philosophical’, whose main ideas will have been discussed in the previous chapter. Again, while a systematic retrieval and analysis of all literature of this sort would no doubt constitute an important method of exploring how social justice is conceptualized or understood (indeed, an aggregation of such perspectives could tell us how people—namely, the authors of such publications—think about social justice in public health), such a project would constitute a study in and of itself and does not fit within the scope of a *review* of literature that can tell us what has previously been reported about the perspectives of people and organizations.

Given that the demarcation between ‘empirical’ and ‘not empirical’ can sometimes be unclear even in the presence of the above parameters, another straightforward assessment applied in this review simply considered whether the literature was ‘empirical’ in a sense similar to my study (see Chapter 4); that is, one that uses standard research methods to generate data about the perspectives, opinions, attitudes, beliefs, experiences, actions, behaviour, and so forth, of organizations or people external to the publication/study authors. This would include both quantitative and qualitative studies employing surveys, questionnaires, observations, interviews, focus groups, document analyses, and so forth. Given the population of interest to this study—public health policy-makers—literature exploring the perspectives of individuals or organizations involved in public health policy and practice (e.g., public health policy-makers, practitioners, and public health agencies as opposed to lay citizens or other organizations) were considered particularly relevant.

The rationale for establishing the scope of this review as such is that one should reasonably expect literature addressing the relevant elements of my particular research questions (or closely related questions) to (a) include the term ‘public health’, (b) include the term ‘justice’ (which would capture ‘social justice’) or closely related terms, and, if describing an empirical study of people’s perspectives, (c) include a term indicating the study’s empirical

method(s). If this is plausible, as I believe it is, then these searches should capture the literature most relevant for the purposes of this review.

### **3.2 Search results and findings**

My literature searches yielded 622 publications. The removal of duplicate results and an analysis of titles and abstracts led to the exclusion of 555 publications, which left 67 in the remainder. An analysis of the full text of these 67 publications resulted in 49 being excluded, leaving 18 to be included in the review.

The majority of the literature failed on multiple criteria of relevance. A significant proportion of publications were returned in the search due to mentioning ‘criminal justice’, but were not relevant to either the context or concept of interest. The inclusion of justice-related search terms like ‘justice’, ‘equity’ and ‘fairness’ was responsible for the retrieval of numerous publications lacking conceptual relevance, as these publications would tend to present these terms either in introductory or concluding remarks with no significant engagement with the concepts. The inclusion of empirical search terms like ‘document’ and ‘empirical’ retrieved many publications that had no empirical component, which also led to the exclusion of many publications.

Ancillary searches resulted in the inclusion of 4 additional publications, for a total of 22. The following sections synthesize and describe key findings from this literature and conclude with an analysis of gaps in current knowledge related to this study.

#### *3.2.1 Perspectives on social justice in public health policy and practice*

This search identified very few studies that have explicitly explored perspectives on social justice in the context of public health policy and practice. Out of these studies, no literature was identified that explicitly explored *public health policy-makers’* perspectives on the concept and

role of social justice. With that said, a peripherally relevant literature was identified that examined perspectives on related concepts, like health equity and fairness; however, given the conceptual and theoretical complexity and ambiguity associated with the relationship between social justice and values like ‘health equity’ and ‘fairness’, it cannot simply be assumed that studies examining these concepts examined, or provide insight into, the concept of social justice and how it is conceptualized and used in practice. However, the insights potentially provided by such literature should not be entirely discounted. Thus, this section will review the literature that explicitly explores the concept of social justice in public health policy and practice and the following section will discuss the most relevant peripheral literature that addresses related concepts.

Perhaps the most relevant publication identified in this review was a brief commentary by Edwards and Davison (2008) that sought to review the “social justice orientation” (p. 130) of the Public Health Agency of Canada’s (PHAC) statement on the Core Competencies for Public Health in Canada (a document that outlines what PHAC considers to be the essential knowledge, skills, and attitudes necessary for the practice of public health in Canada). Consisting of an analysis of this single document, the authors reviewed each of the thirty-six competencies outlined in order to identify “either explicit or implicit references to social justice attributes” (p. 131). While the discussion of ‘social justice attributes’ in this article is more robust than any other reviewed in this chapter, the exploration of these attributes was ultimately rather limited (compared to the impressive scope and variation identified in Chapter 2), which is likely attributable to the fact that a more thorough examination likely fell outside of the scope of what the authors were principally attempting to achieve with their analysis. The authors found that there are no competencies with an explicit reference to social justice, that related terms like ‘disparity’, ‘injustice’, and ‘fairness’ are absent from the competencies, and that social justice is mentioned only once in a preamble to the listing of the competencies (“Important values in

public health include a commitment to equity, social justice and sustainable development...” (Public Health Agency of Canada, 2008, p. 3)). Given the importance attributed to the value of social justice in the statement’s preamble (and the authors’ general conviction that social justice constitutes a core value of public health), the authors concluded that “social justice principles should be integrated into all of the existing domains for core competencies” (Edwards & Davison, 2008, p. 132). As such, this study identified a shortcoming in how the value of social justice is described, applied, and operationalized for public health policy and practice in Canada, and points to the significance of further exploring the ‘social justice attributes’ that ought to be integrated into the competencies and actual practices of public health professionals.

These findings resonate with similar research conducted by Schröder-Bäck and colleagues (2012), who examined the European Union’s health strategy (through an analysis of the white paper *Together for Health*, in which the strategy is outlined). They found that social justice is similarly named as an important value but is only accompanied by a brief description. Both of these studies’ findings perhaps reflect Giacomini and colleague’s (2009) findings from their more general analysis of ethics frameworks within Canadian health policy documents, which were that the treatment of ethics tends “to play a more decorative than developmental or foundational role” (p. 68), and that, in particular, “notions of justice remain open to disparate interpretations” (p. 67). This is a similar trend to have been found in pandemic plans (Derpmann, 2011; Garoon & Duggan, 2008; McDougall, 2010; Thomas, Dasgupta, & Martinot, 2007; Uscher-Pines, Omer, Barnett, Burke, & Balicer, 2006). Taken together, these studies illustrate that the value of social justice is often identified in public health policy documents as an important value but is not discussed in such a way that explains how the value is meant to be understood and interpreted or what it requires for policy and practice. This may correspond to a trend identified by Gopalan and colleagues (2011), who found that the concept of ‘health equity’, while having secured a position in health policy-making in Orissa, India, is almost

entirely neglected following the agenda setting process. That is, when it comes to moving beyond agenda setting to the stages of policy development, implementation, and evaluation, attention to the value of health equity was found to be ‘deserted’. Given Edwards and Davison’s findings above, it may be appropriate to similarly suggest that, for all intents and purposes, the value of social justice was ‘deserted’ following its identification as a core value in PHAC’s core competency statement.

Beyond studies analyzing health policy documents, the most significant findings regarding perspectives on social justice in public health come *indirectly* from studies that have examined the broader range of ethical values or ethical issues in public health. For instance, while not intending to examine perspectives on social justice *per se*, a study by Baum and colleagues generated findings relevant to the value of social justice that resulted from an exploration of the ethical challenges faced by public health practitioners in Michigan (Baum, Gollust, Goold, & Jacobson, 2009; Gollust, Baum, & Jacobson, 2008). The study’s findings about social justice are cited here in their entirety given their relevance:

Many academics and practitioners perceive a philosophy of social justice to be foundational in public health, yet few of the participants used this particular terminology when asked to identify underlying values...Participants described a commitment to the concept of fairness, an important element in any construct of social justice, but the term fairness took on a wide variety of meanings in our data, including equal treatment across population groups, provision of services to those in greatest need, and expectations that individuals pay their fair share for services according to their abilities. Similarly, few participants offered what might have been predictable, traditional utilitarian reasoning (e.g., trying to do the most good for the most people). Several emphasized the importance of having evidence to support programming decisions and of using public dollars efficiently. Others emphasized the importance of respecting individuals’ autonomy or including community values in program decisions. These values are not necessarily inconsistent with social justice and utilitarianism, but they nonetheless portray a complex and heterogeneous set of values articulated by practitioners. (Baum et al., 2009, p. 373)

It is important to reiterate that this study did not explicitly seek to understand practitioners' views on social justice. Rather, participants' views related to social justice emerged when engaged on questions related to ethical challenges in their work. As such, this quote reflects the extent of the authors' discussion of practitioners' perspectives on social justice. Other studies exploring public health practitioners' views on ethical issues in their practice have generated similar findings. That is, 'social justice' has been commonly found to be identified as an important value, but given the general focus of these studies on ethical issues and considerations rather than on social justice itself, there has been little exploration of how the value of social justice is understood or how it is used in practice (much like what was found with public health policy and guidance documents, described above) (Bernheim, 2003). Thus, these findings—in particular, that a complex set of values might undergird practitioners' commitments to fairness and social justice in public health—illustrate the importance of *explicitly* and *specifically* examining perspectives on social justice in public health policy and practice in order to develop a more robust understanding of the myriad considerations that might exist when social justice is invoked. Furthermore, it emphasizes the utility of using theory to guide this examination. Using a theoretically robust framework that is sensitive to the 'complex and heterogeneous values' that may be associated with practitioners' commitments to social justice may be necessary to examine and understand these values and their relationship to social justice (Venkatapuram, 2009).

The fact that a multitude of views related to social justice emerge when public health practitioners are engaged on ethical issues should signal the importance of further exploring these views. Indeed, that 'many public health practitioners perceive a philosophy of social justice to be foundational in public health but few use this terminology' should prompt us to carefully examine whether and the extent to which this 'foundational philosophy of social justice' is actually shared among public health practitioners. What is also left unasked is *why*

practitioners might have different meanings of social justice, whether those meanings would become more complex and fuzzy or straightforward and clear if they were to be further explored, and whether those meanings were directly linked by practitioners to the particular ethical and practical considerations found in their area of public health practice. As articulated in the previous chapter in my critique of the treatment of social justice in the public health ethics literature, various meanings of social justice (e.g., equal treatment, provision of services to those in greatest need, and so forth) and their particular normative considerations or demands should not be taken for granted and be assumed to cohere within a catch-all value like ‘social justice’. If it is possible that public health professionals have different (and perhaps conflicting) perspectives about the meaning and scope of social justice in their practice, then this ought to be better understood, particularly if social justice is meant to be a core, animating value that guides policy and practice. Indeed, we may have difficulty uniformly incorporating ‘social justice attributes’ into the Public Health Agency of Canada’s thirty-six core competencies for the practice of public health (Edwards and Davison’s project) if there is substantial uncertainty or disagreement among public health professionals about what those attributes ought to be.

A third study aligning with this trend of exploring ethical issues in public health sought to “analyse the receptiveness of the population of French-speaking Quebecers to certain ethical principles promoted by public health authorities during the AH1N1 [influenza] vaccination campaign”, and thereby “add to the limited number of empirical studies that examine the population’s perception of ethical values” (Massé & Déry, 2014, p. 876). This study found that participants associated two components of the vaccination campaign with the value of social justice—equal access to the vaccine and the act of vaccination, as well as the criteria for priority access to vaccines—and found that feelings of injustice were in some cases fueled by the inclusion of priority access groups, which some participants felt breached the principle of equality and universal access (which are enshrined in the Canada Health Act). As alluded to

previously, due to the broad scope of studies like these, which do not focus explicitly or specifically on the value of social justice but rather on ‘ethical values’ or ‘ethical issues’, findings about how social justice is conceptualized or used in practice are relegated to one or two sentences and tend to constitute a fairly shallow exploration. Nonetheless, these studies remain important because they reinforce the ostensible importance of the value of social justice to public health practitioners while at the same time pointing to the need to further explore the meaning and scope of this value and how it is used in practice.

Breaking from this tendency of exploring ‘ethical issues’, Gubrium and colleagues (2014) specifically explored the ways young parenting women (aged 16-21) who received social welfare in the New England area conceptualized social justice. While the link to public health policy and practice is not made explicit and the participants of this research were members of the public rather than those involved in public health policy and practice (which ultimately renders the findings of this study potentially less relevant to my research), the study did attempt to examine perspectives on the connections between health and social justice. Several of the study’s findings spoke to the salience of *caring* in the participants’ lives: participants frequently observed behaviours and models of not caring (including within institutions like government agencies and health care), and saw ‘caring’—viewed as someone having a deep commitment to making his or her own community a better place for people to live—as crucial to reducing health disparities. The authors theorized that “people develop a sense of caring to the extent that they see that there are real possibilities that can lead to accomplishing things that they consider meaningful, worth doing” (p. 133). Gubrium and colleagues concluded that, “if the field of public health aims to reduce youth sexual health disparities and promote health and wellbeing, then it may require assuring that we see that they have the capability to do valuable things and reach valuable states of being, particularly so through a lens of solidarity” (p. 135). This study, along with others that explore lay understandings and interpretations of phenomena like health

disparities (Calnan, 1987; Davidson, Kitlinger, & Hunt, 2006; Davidson, Mitchell, & Hunt, 2008; Macintyre, McKay, & Ellaway, 2005; Popay et al., 2003; Popay, Williams, Thomas, & Gatrell, 1998; Putland, Baum, & Ziersch, 2011a, 2011b; Reutter et al., 2005), point to the importance of comparing and contrasting how lay perspectives about health and health disparities relate to perspectives on social justice among public health policy-makers and practitioners. While no doubt an important area of inquiry, this is beyond the scope of this review and this study.

A small number of relevant studies were also identified from within the social psychology literature. For instance, Thrasher and colleagues (2010), in a survey study of residents of Mexico City, sought to “assess the factors that correlate with citizens’ perceptions of the distributive, procedural and interpersonal justice of smoke-free laws, as well as how these perceptions are related to support for and intention to help enforce these laws” (p. 787). This study found that both distributive and procedural forms of fairness were associated with citizen support for smoke-free laws (e.g., higher perceived fairness correlated with higher support for the law), and concluded that “those seeking to implement smoke-free, and perhaps other kinds of health policies, should focus on ensuring that citizens believe that the outcomes of the legislation will be just and in their best interest” (p. 792). This study, however, explored only the role of perceived fairness, and did not seek to examine perspectives on what fairness might actually entail. Thus, this study is another example of research that emphasizes the significance of social justice to public health (i.e., policies and practices should be perceived as socially just if they are to be successfully implemented), but does little to explore or elucidate what this means (i.e., the actual elements participants believed must exist in order for such laws to be perceived as fair). This is a common shortcoming of much social psychological research on justice: it strives to say something about the role of *perceived* justice for the acceptability and justification of different behaviours but typically falls short of attempting to understand what

justice actually ought to entail from participants' points of view. Miller (2001) contends that this may be because "empirical social scientists attempt to bracket off the question of what justice really is, and see themselves as investigating 'justice beliefs' or 'justice behavior' without theoretical presuppositions" (pp. 42-43) in order to avoid getting drawn into a 'quagmire' about the normative relevance of individuals' beliefs about justice. I address this supposed 'quagmire' in the context of my study in the next chapter.

As another example of this, Eisenman and colleagues (2004) sought to describe "variations in perceptions that the public health system will respond fairly to one's needs in a bioterrorist event" (p. 146). While a reported 72.7% of respondents in this study perceived that the public health system will 'respond fairly', this was based on a single outcome variable to the following question: "If there is a bioterrorist attack in LA, do you think the County's public health system will respond fairly to your health needs regardless of race, ethnicity, income or other personal characteristics?" (p. 146). The only available responses were 'yes', 'no', 'don't know', or 'refused', where 'perceived fairness' was defined as a 'yes' response. Hence, while this study purports to say something about the public's perceived fairness of the public health system, it is flawed in that it is entirely ambiguous as to what respondents—and study authors—considered a 'fair response' in the first place. Different people may have different ideas about what a fair response entails, which has significant implications for both how public health activities are designed by public health professionals and how they are evaluated by the public. In other words, while a majority of participants in Eisenman and colleagues' study perceived that the public health system will 'respond fairly' to a bioterrorist event, this means very little if competing conceptions of what constitutes 'fairness' existed among study participants, as a response by the public health system likely cannot accord with numerous conceptions of fairness.

This issue has been identified by political philosophers as a significant limitation in the appropriateness of social scientific investigations of perspectives on social justice. For instance, Miller (2001) argues that “political philosophers have been unwilling to take [empirical data about people’s perspectives on social justice] seriously. On the one hand, they have argued that the research reveals not people’s considered opinions about what justice is, but rather only their momentary response to a questionnaire or contrived experiment” (p. 42). However, this criticism may in fact be better aimed at the depth and relevance of the social science methodologies that have traditionally been used for these sorts of studies. Indeed, beyond quantitative surveys and social psychological experiments, there is a paucity of qualitative, in depth, empirical studies on this topic (even outside the domain of public health), which have greater capacity to explore the reasons, justifications, and explanations that individuals might offer in their judgments of what they perceive to be ‘socially just’ or ‘fair’.

By contrast, Ridde (2008) used the more robust methods of ‘concept mapping’ and focus groups in Burkina Faso to engage members of interest groups and appointed officials—considered ‘specialists’ in health policy—in order to understand their views on equity and social justice. While not necessarily situated within the context of public health policy and practice, this study was considered relevant for this review due to its explicit focus on perspectives about social justice among those considered ‘specialists’ in health policy. Ridde found that, when engaged on the concept of social justice, officials largely brought up processes “for which the responsibility for implementation was most often located far outside their own sphere of activity” (p. 4). He also found that key concepts like human rights, democracy, and good governance were perceived as being related to the concept of social justice, and that the ‘rational and efficacious management of development aid’ was considered most important when describing social justice—a finding perhaps unique to Burkina Faso and other aid-dependent countries. Interestingly, Ridde found that participants considered ‘equity of access to basic

social services’ to be important for social justice, but he “did not discuss with the participants their definition of ‘equity’” (p. 7). This reflects a broader trend within this literature; namely, that discussions of social justice commonly evoke discussions of many other normative concepts, like equity, democracy, and human rights, but beyond the identification of these terms, little is done to explore their meaning or relationship with social justice. This issue was identified in the previous chapter with respect to how common definitions of ‘health equity’ invoke the terms ‘just’ or ‘fair’ (i.e., ‘health equity means unjust differences in health’) without further defining what is meant by these terms. It is unclear whether researchers simply presume their participants conflate terms like ‘social justice’, ‘equity’, or ‘human rights’, and thus do not explore this further, or whether researchers lack the analytical or methodological capacity, or perhaps the theoretical framework, to investigate what participants mean by these terms. This issue seems to plague policy in this area as well. For instance, Gopalan and colleagues (2011) found that the ‘health equity approach’ in Orissa, India, while specifically aiming to attend to the needs of population groups who may be vulnerable based on geographical accessibility, social status, gender, or economic status, was ultimately not specific regarding how to materialize equity goals. They found that plans specifically included a ‘health equity approach’ to aim for ‘equitable allocation’, but failed to articulate exactly what an ‘equitable allocation’ requires.

Finally, a Michigan-based study by Baum (2010) consisting of focus groups explored, in part, public views on issues of justice or fairness in the allocation of resources expected to be scarce during a pandemic. She found that participants viewed no single principle or allocation scheme as preferable, that many made utilitarian arguments emphasizing approaches that were ‘best for society’, and that many favoured the use of a lottery for the distribution of scarce resources. Myriad other considerations arose in Baum’s study, including the allocation of resources to those who would be more likely to benefit, those who would be hardest hit by a

pandemic virus, those who would benefit the most, and those who would be most vulnerable. Baum found that some participants favoured the prioritization of children, health care workers, and other first responders, but that participants broadly objected to developing allocation policies based on social value. The identification of multiple principles and no clear preference for an allocation scheme is reflected in several other studies reporting perspectives (from the public, stakeholders, or documents) on the allocation of resources during a pandemic (Kotalik, 2005; Nordgren, 2015; Prehn & Vawter, 2008; Ritvo et al., 2013; Silva et al., 2012; Uscher-Pines et al., 2006). This study, taken together with those studies exploring participants' views on ethical issues in public health, illustrate that an ecology of values appears to be at work in many stakeholders' perspectives on social justice (though, this remains unclear or uncertain without further targeted exploration). These findings indicate that people's perspectives of social justice are likely not simple or uniform, which should only prompt us to further investigate these perspectives and do so in a manner that is capable of in-depth exploration and engaging with the analytic insights that can be offered by social justice theory.

Several other studies have emphasized the importance of directing further efforts towards understanding the concept and role of social justice in public health policy and practice. For instance, a study by Neumann and colleagues (2007), which investigated the ways of defining and measuring the value of public health services through interviews with public health professionals and literature syntheses, found that "understanding public health's intangible values was the most difficult conceptual and measurement challenge" (p. 2177) faced by public health professionals. This study reported that participants considered the so-called 'intangible value' that public health has to be a unique trait, and characterized one of these 'intangibles' as public health's commitment to social justice. Other studies highlight that there may be a lack of an 'equity dimension' and theoretical underpinning to much aetiological and evaluative public health research, which may explain limited progress on reducing health inequities (Petticrew,

Whitehead, Macintyre, Graham, & Egan, 2004). This reflects a larger trend found within this literature, which suggests that the incorporation of evidence of health inequities into public health policy-making may be stymied by a lack of existing tangible, evidence-informed strategies (National Collaborating Centre for Determinants of Health, 2011), or the fact that social and structural inequities may be less visible in municipal public health (Tallarek née Grimm, Helgesen, & Fosse, 2013). In all, there are an increasing number of studies that in one way or another express concern about incorporating, operationalizing, and realizing the value of social justice in public health, but other than identifying this issue and the presence of this value, very few have sought to explore this further.

### *3.2.2 Peripheral literature: Perspectives on health equity and fairness in public health policy and practice*

Beyond studies that have explicitly explored perspectives on *social justice* in public health policy and practice, the body of literature most relevant to this review is that which has explicitly explored perspectives on *health equity* in public health. Again, because studies of this sort tend to not explicitly state the relationship between health equity and social justice or explore participants' perspectives on this distinction or relationship, it is unclear exactly how perspectives on health equity relate to perspectives on social justice. However, because of the ostensible conceptual proximity between health equity and social justice (see Chapter 2), the most relevant literature will be reviewed here in order to highlight important findings for this study.

The most relevant study within this peripheral literature is a recent study by Rizzi (2014), which explored how equity is understood as a concept and in practice by public health frontline staff in Ontario. Fortunate for my present purposes, Rizzi's study involved a comprehensive review of public health literature that focused "on health equity or any related

content, such as social determinants of health, access to care, social justice in health, and equity generally” (p. 17). Her review yielded a total of fifteen papers, six of which being empirical studies (all of which having been captured and discussed in my review as well).<sup>2</sup> The main finding from Rizzi’s review was that a major gap exists in this literature regarding perspectives on equity among public health frontline staff. Reflecting the findings of my review in section 3.2.1 of this chapter, Rizzi also concluded in her review that “[f]undamental principles of social justice are present throughout literature on health equity, however research examining the processes of moving these ethical principles and theories into practice seems to be limited” (p. 31). As such, Rizzi’s literature review reaffirms that (a) there is a major gap in the literature regarding perspectives on *social justice* among any population, including public health frontline staff and policy-makers, and that (b) social justice is routinely mentioned in the health equity literature, but that this literature, which includes empirical studies on perspectives on health equity, fails to explicitly examine the relationship between health equity and social justice and explore what this means for practice. Given health equity’s reliance on social justice to do much of its normative work (as argued in Chapter 2), this strongly suggests that the explicit investigation of perspectives on social justice should be prioritized, and that studying the relationship between the values of health equity and social justice in practice in particular could

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<sup>2</sup> Rizzi’s review involved a search of PubMed, Ovid, Sociological Abstracts, Google Scholar, and Google for several phrases and combinations of key words, including “health equity, health inequity in Canada, health inequality, health disparity, social determinants of health, poverty and health inequity, public health, Canadian public health, frontline health care staff, Canadian health policy, knowledge translation in health, knowledge to action framework, equity in practice, and Ontario Public Health Standards” (p. 17). In Rizzi’s words, “[a]ll material had to focus on public health” (pp. 17-18), was limited to the English language, and included literature published after the year 2000. Thus, it appears Rizzi’s literature review is in some ways more limited in its scope and analysis of relevance than mine, but had the capacity to identify literature that mine might not have (i.e., by using search terms like ‘social determinants of health’, ‘health inequality’, and ‘health disparity’). Given that my review identified every publication captured and reviewed by Rizzi, I am confident my review did not exclude literature relevant to my study problems and research questions.

be illuminating not only in an effort to understand the concept and role of social justice in public health, but also to understand the concept and role of health equity.

Rizzi's study itself found that public health frontline staff used terms like justice and fairness when describing how they understood health equity. For instance, Rizzi reported that the "theme of *fairness* was another dominant [frontline staff] descriptor of health equity, and [was] often made in reference to the concept of social justice" (p. 47). She quotes one participant as saying "[e]quity just means fairness which I think is contrasted by equality" (p. 47). Yet, despite the fundamental relationship between social justice and fairness to participants' conceptualizations of health equity, no attempt was made to understand how participants understood the concept of social justice or fairness, the exact relationship of these concepts to health equity, or their particular role in public health policy and practice. At one point, it appears that Rizzi considers this to be an area of inquiry that is perhaps not feasible to explore when she says: "[f]or frontline staff, social justice and fairness were important considerations in how they practiced, noting that this may influence their day-to-day work. This point of view is consistent with arguments in the literature about difficulties of addressing health equity due to perceptions of equity being highly subjective and context-specific" (p. 47). Indeed, the 'subjectivity' and 'context-specificity' of social justice is alluded to several times in Rizzi's study, and may account for why the examination of this concept was neglected. Unfortunately, treating the concept of social justice as 'subjective' simply acts to reify the problem at hand, which is that social justice cannot be meaningfully defined, discussed, and operationalized. Acknowledging the putative importance of the value of social justice to public health should warrant a serious investigation of its contents, role, and scope rather than dismissing it as merely 'subjective'. What Rizzi's study does do, however, is affirm once again that social justice is identified as an important value among public health practitioners and plays

an important role in how health equity is understood, and points to the fact that it is hitherto unknown how practitioners understand the value of social justice or how it is used in practice.

A similar, relevant publication is that of Knight (2014), who sought to explore the meaning of health equity from the perspectives of 25 US experts on the social determinants of health and community leaders working to advance health equity. She categorized overarching themes related to the meaning of health equity in terms of ‘fairness, justice, and equal opportunity’, ‘focus on conditions’, ‘systemic and cultural’, and ‘a positive vision achieved through collective action’. In particular, Knight found that it was generally assumed among participants that creating ‘equity’ in the conditions that determine health will allow people to realize their full health potential and ultimately eliminate health disparities. As one participant of Knight’s study expressed, “you cannot have equity without attention to how the past works to create injustice and inequity” (p. 191). In general, Knight reported that participants’ definitions of health equity were consistent with common definitions, emphasizing “the concepts of ‘fairness’ and ‘justice’ and the belief that inequities are ‘avoidable’” (p. 193). While not explicitly engaging with participants regarding their views on what constitutes social injustice (or even ‘equity in the conditions that determine health’), Knight stated that “[p]articipants described the role of the field in addressing health inequities as being grounded in the evidence base, as well as in the value of social justice, which they believed were mutually reinforcing. Recognizing that social justice underlies health equity requires strong engagement with the political process” (p. 192). Furthermore, she found participants believed that “deciding what is fair or just requires a value judgment, and the answer to such questions cannot be found in the evidence base” (p. 193). This again seems to speak to the perceived ‘subjective’ nature of social justice. She concluded by recommending that the field of public health take more responsibility for addressing health inequities and shift its work in meaningful ways that recognize the *structural* determinants of health inequities. This study therefore reiterates the importance of

examining the myriad assumptions and values about social justice that appear to undergird conceptions of health equity among public health policy-makers and practitioners.

Beyond engagement with public health practitioners, some studies have sought to explore how equity is understood or used in public health policies and other documents. The most robust example of such a study was conducted by Pinto and colleagues (2012), who explored how and the extent to which an equity lens was incorporated into provincial public health standards in British Columbia and Ontario by analyzing the BC Core Functions Framework and the Ontario Public Health Standards (OPHS). They found that the majority of the discussion of inequities occurs within the introductory materials of these documents (affirming a trend already identified in this review), that both documents acknowledge the limited ability of public health to reduce health inequities if it acts alone, and that an analysis of the “systemic factors and a deeper questioning about the roots of inequities is not apparent in either set of documents” (p. 8). This, again, echoes the treatment of ‘social justice’ in similar health policy documents, as described in the preceding section.

With that said, the authors found that both documents identify the reduction of health inequities as an important goal and frame this goal as instrumental for the improvement of overall population health. However, while the BC Framework includes an equity lens that is “in place to ensure the health needs of specific populations are addressed” (Population Health and Wellness, 2005, p. 20), the authors found that the focus on reducing health inequities is not evenly maintained throughout the OPHS. Indeed, Pinto and colleagues found that only a few of the twenty-six OPHS protocols explicitly identified ‘reducing inequities’ as a goal. The authors hypothesized that this is reconciled within the OPHS by its framing of the reduction of health inequities as a *societal outcome* rather than a Board of Health outcome, meaning that no single protocol is necessarily responsible for achieving this goal. Furthermore, while the BC Framework explicitly specifies an equity lens for all core programs, the OPHS focuses on

‘priority populations’ as a “proxy for equity” (Kothari et al., 2013, p. 11). The authors indicate that Ontario’s focus on ‘priority populations’ was a move to enable health units to independently determine which groups ought to be prioritized as a matter of equity. Pinto and colleagues suggest that the process of using an equity lens within the BC Framework translates into “more specific and robust methods to address health inequities in the development of BC’s Model Core Program’s papers” (Pinto et al., 2012, p. 8), and that Ontario’s lack of specificity may reflect greater caution in identifying specific actions that Boards of Health would have been accountable for accomplishing.

However, despite the explicit examination of equity in these policy documents and these important findings, it is still unclear exactly (a) how equity is understood or interpreted within these policy documents and (b) how the study authors themselves interpreted equity within their analysis of the documents. First, Pinto and colleagues found that both the OPHS and BC Framework defined health inequities as health inequalities that are deemed unnecessary, avoidable, unjust, and unfair, which mirrors Whitehead’s influential definition discussed in the previous chapter. While these definitions provide some insight into how these documents interpret the concept of health equity, they do not provide any insight into what should be considered ‘unnecessary’, ‘avoidable’, ‘unjust’, or ‘unfair’, and therefore leave much of the definition open to interpretation (the hazards of doing so having been examined in the previous chapter as well). This was recognized by Povlsen and colleagues (2014) in their similar investigation of whether the term ‘equity’ was applied in selected public health documents from Denmark, Finland, Norway, and Sweden. In particular, Povlsen and colleagues found that “[e]ven though it is recognised [within these documents] that equity is a normative concept demanding political action, this has not always been explicitly stated or problematized” (p. 238). That is, many of the normative commitments entailed by health equity are left unarticulated or unexplored. Second, Pinto and colleagues stated that, “[i]n order to remain open to various

conceptions of equity within the documents, all team members shared their own views on equity and how this influenced their reading of the documents” (Pinto et al., 2012, p. 3) (these views, or even the attributes or considerations that might have been present in these views, were not subsequently discussed). As such, it is unclear which analytic considerations or criteria were used by the study authors in analyzing these documents. Engaging social justice (or equity) theory could at the very least provide some transparency in regards to the types of considerations or accounts that are used in analyses like Pinto and colleagues’.

Other studies opted to focus not on the concept of equity as a whole, but rather on a particular component of equity. For instance, Daley and MacDonnell (2011) conducted a critical discourse analysis of selected health services sector access and equity documents in order to identify dominant and counter discourses related to the inclusion or exclusion of LGBT populations. They found that two dominant discourses exist within this literature: (1) multicultural discourse, and (2) diversity discourse. These discourses were found to represent a broad conceptualization of diversity, and tended to recognize that *any* group has a culture of its own and must be respected. As such, the authors suggested that these dominant discourses may only minimally represent LGBT people by “offering fleeting reference to these populations vis-à-vis the inclusion of sexual orientation as a category of diversity” (p. 5). Three counter discourses were also found: (3) social determinants of health discourse, (4) anti-oppression discourse, and (5) citizen/social rights discourse, which tended to extend the requirements for equitable access to include a focus on structural issues that affect the health of LGBT populations, and giving rights to equal treatment regardless of sexual orientation or gender identity. Overall, Daley and MacDonnell’s particular analysis of the inclusion of LGBT populations in health services sector equity documents illustrates that multiple and competing discourses may operate within such documents, and that, within these documents, LGBT populations are largely either not represented or only marginally represented. This only further

emphasizes the importance of interrogating the assumptions and values that undergird perspectives on health equity, like social justice (e.g., does health equity require the remediation of injustices experienced by LGBT populations? Are such injustices any worse—any more unjust—than injustices experienced among other ‘minority’ populations? Whose interests are accounted for in conceptions of social justice and health equity?).

Finally, in a learning exchange between Communities for Health (C4H) in England and the Racial and Ethnic Approaches to Community Health across the US (REACH US), key aspects of what each community of practice believed works and doesn’t work in reducing inequities was explored (Blanchard et al., 2013). One of the key themes identified from the exchange was that organizations have strong guiding principles formed upon a bedrock of values like social justice and human rights, but that several obstacles exist to achieving the reduction of health inequities. For instance, the exchange found that participants believed political and power structures create imbalances that give rise to conditions that lead to health inequities, and that disparities in access to health services continue to drive health inequity. The exchange also found that the majority of respondents in both communities reported a lack of funding as being the greatest barrier impacting sustainable change in community work, and that despite the widespread acknowledgement that health inequities are driven by unequal access to power, opportunities, resources, and so forth, these issues are not being addressed in high-level policy or commissioning structures. The US projects in particular were more explicit in identifying race as a key factor in health equity, whereas the majority of English projects placed less emphasis on race as a primary factor in health inequalities, focusing instead on socioeconomic status. This study therefore emphasizes the importance of attending to the potentially context-specific understandings that might exist for values like health equity and social justice.

### 3.3 Gaps in knowledge

Beyond the deficiencies and gaps already discussed above, this review demonstrates that five significant gaps exist in the current empirical literature: (1) While social justice is routinely identified as a value in public health policy documents and among the perspectives of those engaged about ethical issues and considerations in public health, very little has been done to further explore perspectives on how this value is understood and used among public health policy-makers and practitioners; (2) More attention has been paid to exploring perspectives on health equity than on social justice, despite a trend in this literature (and a theoretical reason outlined in the prior chapter) suggesting that conceptualizations of health equity are built upon assumptions and values related to social justice; (3) Despite the fact that social justice and health equity are normative concepts, no studies exploring perspectives on social justice or health equity have robustly engaged with the vast normative theoretical literature on social justice in order to situate or understand these perspectives; (4) Due to the neglect of this normative theoretical literature, little has been said about how descriptive findings about perspectives on social justice, health equity, or fairness ought to inform normative recommendations for the pursuit of these values; and (5) No attention has been paid to whether and the extent to which perspectives on social justice, or health equity for that matter, might differ in distinct programmatic areas of public health policy and practice (e.g., chronic disease prevention vs. public health emergency preparedness and response).

Investigations of perspectives on general ethical issues and ethical considerations in public health policy and practice are essential, yet such studies have thus far not yielded a robust examination of perspectives on the meaning and role of social justice, a value consistently identified as one of public health's core values. Thus, a unique contribution to this corpus would involve specific attention being paid to the investigation of perspectives on social justice as it is understood and used in public health policy and practice. Furthermore, investigations of

perspectives on health equity, while also essential given the prominence of the value in public health, should not be seen as necessarily enhancing our understanding of how social justice is interpreted and used. In fact, such studies should ultimately be seen as pointing to the importance of understanding the value of social justice *in order to* better understand the ways in which health equity itself is interpreted and used.

Given the normative character of the concept of social justice as well as an emerging scholarship on the normative theoretical dimensions of social justice in public health, investigations of perspectives on this value ought to be robustly guided by normative theoretical considerations and accounts—something that has hitherto been entirely lacking in this empirical literature. Invoking the value of social justice in public health in the first place attunes our attention to the prescriptive; that is, it points to the normative aims and principles that ought to inform the organization and practice of public health. Yet, without linking information about people’s perspectives on social justice to the normative debate, it is unclear how these perspectives might help to enhance our understanding of the value’s normative attributes or *desiderata*. The perspectives of those who practice public health should therefore be explored and analyzed with the aim of specifying, clarifying, and operationalizing these normative commitments.

This literature also illustrates that efforts ought to be made to explore whether different norms exist across different programmatic areas of public health policy and practice, rather than assuming perspectives on social justice are, or can be, understood universally across different domains of public health. Central to an investigation of this sort should be an examination of what the potential policy and practice implications might be of a finding that different social justice considerations and norms exist among public health professionals in different domains of public health policy and practice.

In sum, to fill these knowledge gaps this review has established that concerted efforts ought to be undertaken to specifically explore perspectives on the meaning and role of social justice in public health policy and practice. Studies on ethical issues in public health and the concept of health equity have been insightful but have only further emphasized the significance of exploring perspectives on social justice. Neglect of the emerging normative theoretical scholarship in empirical studies to date should also be rectified by robustly engaging with this literature in such a way that aims to situate information about people's perspectives within the normative debate, with the overall goal of clarifying and enhancing the normative guidance imbued by the value.

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## Chapter 4

### Methodology and methods

*“...the philosophy of justice cannot be separated from its sociology; in other words... conceptions of justice make sense only when placed in their appropriate social contexts.”*

- David Miller, 2001

Thus far, this thesis has illustrated that public health is widely perceived to be ‘inextricably linked’ to social justice. The term ‘social justice’ is central to the mission and values statements of public health organizations. It is identified as a ‘core value’ that is routinely invoked as a ‘foundation’ of public health. Yet, outside of the theoretical literature the term is typically unaccompanied by a robust definition, and the many details and extensive variation found in theoretical conceptions of social justice are rarely, if ever, acknowledged. In addition, the few empirical studies poised to tell us something about public health professionals’ perspectives on social justice have signaled the ubiquity and putative importance that people and organizations bestow to the value of social justice in public health, but have failed to explore how the value is understood and used among those charged with interpreting, applying, and pursuing this value in policy and practice.

While some philosophical accounts have recently been proffered that specify the contents and role of social justice in the context of public health, these contributions lack morally significant empirical information that should be considered integral to an understanding of social justice in public health; that is, how social justice is understood, negotiated, and pursued *in practice*. If the value of social justice is to be simultaneously conceptually robust and applicable within the messy context of public health policy and practice, it should be understood in terms of

the theoretical insights afforded by social justice theory as well as the practical insights afforded by understanding the way(s) in which it is understood, experienced, and pursued in practice.

This chapter re-introduces the study's research objectives and questions and describes the methodology and methods employed to answer them. These study elements were formed on the basis of the theoretical and empirical background outlined in the previous two chapters, in addition to the rationale for conducting this study supplied in Chapter 1.

#### **4.1 Research objectives**

There are four research objectives that guide this study:

1. To explore the perspectives of public health policy-makers regarding the meaning of social justice and the role the value plays in the context of their practice.
2. To examine the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health (chronic disease prevention and public health emergency preparedness and response) are similar or different in regards to the meaning and role of social justice.
3. To identify key areas of normative social justice theory that could benefit from being enhanced or refined given the findings from objectives 1-2.
4. To identify key areas in which normative social justice theory might help to enhance or refine the meaning and role of social justice in public health policy and practice given the findings from objectives 1-2.

## 4.2 Research questions

There are four research questions that motivate the design and data collection for this study:

1. What are public health policy-makers' perspectives on the meaning of social justice and the role the value plays in the context of their practice?
2. To what extent are the perspectives of public health policy-makers involved in different programmatic areas of public health (chronic disease prevention and public health emergency preparedness and response) similar or different in regards to the meaning and role of social justice?
3. In what key areas should normative social justice theory in public health be enhanced or refined given this study's empirical findings?
4. Given this study's empirical findings, in what key areas might normative social justice theory help to enhance or refine the meaning and role of social justice in public health policy and practice?

## 4.3 Methodology

To be clear, methodology can be defined as “a theory and analysis of how research should proceed” (Harding, 1987, p. 2), or an “analysis of the assumptions, principles, and procedures in a particular approach to inquiry” (Schwandt, 2001, p. 161). Most ‘branded’ research methodologies—that is, most well-established, theory-driven approaches to research, like ‘grounded theory’, ‘interpretive phenomenological analysis’, or ‘critical discourse analysis’—circumscribe the sorts of research objectives and questions that, on their view, can be justifiably pursued (Carter & Little, 2007). This is because most research methodologies are often attached to particular paradigms that entail distinct ontological and epistemological commitments—beliefs about the nature of reality and how we can come to know that reality through research

(Atkinson, 1995; Patton, 2001). The upshot is that these sorts of methodologies say something not only about the preferred methods of data collection and analysis, but also the entire theoretical framework for conducting research and analyzing data (Braun & Clarke, 2006). Adopting a branded methodology for this study was therefore unappealing to me because (a) my particular (and weakly held) epistemological and ontological views do not align with those advanced by any branded methodology that I am aware of, and (b) I preferred for my research to proceed in whatever way was best able to answer my research questions and achieve my research objectives. This *pragmatic* approach means that my methodological choices were guided principally by my research objectives and questions, which were formed on the basis of this study's unique theoretical and empirical background and rationale, rather than by any particular methodological orthodoxy (Patton, 2001; Stew, 1996). These methodological choices will be described throughout the remainder of this chapter.

With that said, my own epistemological and ontological views have no doubt influenced the choices I have made in designing and conducting this study, and so they warrant a brief description. This is not a straightforward task, as I cannot claim my own epistemological and ontological views to be entirely unwavering. Broadly speaking, though, I am confident in rejecting positivistic axioms (which, among other things, hold that the researcher can 'capture' facts about the world in propositions that are true insofar as they have an isomorphic correspondence to those 'facts'), much like I am confident in rejecting radical constructionist epistemologies (which, among other things, hold that knowledge is a discursive construction, and that the subjects of research are more or less constituted by the methodologies used to examine them) (Lincoln & Guba, 1985; Madill, Jordan, & Shirley, 2000). Instead, my epistemological views perhaps align most closely with 'critical realism'. While there are many different stripes of critical realism, critical realists typically argue that the researcher is able to describe and

understand some notion of a ‘reality’ (e.g., ‘public health policy-makers’ perspectives on social justice’), but that knowledge of this ‘reality’ is mediated by the researcher’s beliefs, expectations, and interpretations (Archer, 2010; Bhaskar, 1998; Guba & Lincoln, 2000; Madill et al., 2000). Hence, on this account knowledge is seen as fallible and theory-laden, but not *theory-dependent*. As such, critical realism is able to account for variable and multifaceted interpretations of the nature of reality but does not devolve into relativism or a view that must negate the existence of an ‘objective reality’, which in my view plagues some other approaches in qualitative research (Buse, 2015; Madill et al., 2000).

One of the implications of holding this particular view is that I assume the relationship I as a researcher have with research participants and the data generated in this study is interactive and inseparable. Thus, I view the data generated in this study as mutual, contextual, and involving multiple meanings (Lincoln & Guba, 1985). Another implication is that I assume data generated from my empirical research cannot be detached from theory; what I count as data will at least to some extent be determined in light of the substantive theoretical interpretation used in my study (i.e., Chapter 2). This view is in alignment with my interest in explicitly linking the empirical data generated in my study to the ethical debate located in the theoretical literature, as reflected in my third and fourth research questions.

My third and fourth research questions (and their corresponding research objectives) speak directly to establishing this dialogue between my empirical data and normative theory. An outstanding methodological question therefore concerns the manner in which I intend this dialogue to be ‘established’. That is, these questions require that more be said about how I intend to link information about public health policy-makers’ perspectives on social justice with questions of how social justice *ought* to be understood and pursued—a question addressed by the normative theoretical literature.

Research objectives three and four (and their corresponding research questions) are rather modest insofar as their aim is not to produce a normative account of social justice in light of this study's empirical findings and their relationship with existing normative theory (though, I doubt whether shying away from this enormous task should be considered 'modest'). Rather, my aim in linking the empirical data in my study with the normative debate is pragmatic. Like Engel (2009), I take pragmatism to be the view that "epistemic reasons and justifications—such as our reasons for taking a belief to be true or well confirmed—are either determined or can be overridden by practical or prudential reasons or justifications" (p. 185). As such, this study is not seeking to discover some universal and unwavering 'truth' about what social justice is, nor is it seeking to validate normative theory or simply describe perspectives on social justice. What it is ultimately aiming to do is generate empirical information about public health policy-makers' perspectives on social justice, and, in light of this information, explore the practical or prudential reasons and justifications—derived from both theory and interviews—that might exist in supporting the consideration, if not endorsement, of particular considerations of social justice in public health, or in advocating for the modification of how social justice is conceptualized and pursued in practice.<sup>1</sup>

To accomplish this pragmatic aim my study seeks to establish a contextual understanding of the ways in which social justice is discussed in the practice of public health, including how the

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<sup>1</sup> This aim entails a rejection of using either normative theory or empirical information as the 'final arbiter' in generating these practical or prudential reasons or justifications. That is, my aim is not to collect empirical data about policy-makers' perspectives in order to make a judgment about their compliance with particular prescriptive norms found in normative theory (as this assumes the 'correctness' of normative theory), nor is my aim to generate empirical data in order to develop normative theory (as this fails to take seriously the possibility that the empirical information generated could be morally repugnant, warranting efforts to be directed at modifying such empirical 'realities'). Rather, this aim involves being critical of the assumptions of both theory and empirical 'realities', where theory is used to interrogate empirical data and empirical data are similarly used to interrogate theory (Dawson, 2009; Molewijk, Stiggelbout, Otten, Dupuis, & Kievit, 2004).

term is interpreted and used at ‘ground level’ (Ives & Draper, 2009). This is imperative, I believe, because ethical concepts like social justice are not simply superimposed onto a field like public health, and they typically do not logically entail specific policy directions or responses (Giacomini et al., 2009; Jennings, 2015). Rather, when values like social justice are interpreted and discussed in the context of public health policy and practice, either as a result of being gleaned from values statements, the literature, or generated ‘organically’ from public health professionals’ assessment of the issues and challenges faced in their work, the meaning of these values is “transformed and contextualized or localized” (Jennings, 2015, p. 9). As Giacomini and colleagues (2004) contend, context shapes the meaning of ‘declared’ values, like social justice. I argue that a study of this sort should therefore aim to situate theory and, ultimately, the ‘pursuit of social justice’, in practice; instead of normative theory underlying practice, theory is located and understood within practice (Ives & Draper, 2009). Central to this approach is the acknowledgement that what might be ‘basic’ in one context may not be ‘basic’ in another (Timmons, 1999); what might be taken for granted in one context may not be in another. Ultimately, it proceeds with the assumption that perspectives on social justice may be shaped, in part, by the context in which the value is interpreted and applied. The act of locating theory in practice, which is further described further in the data analysis section below, aims to contextualize normative theory such that it is able to elucidate a *pragmatic* understanding of the concept and role of social justice in public health.

#### **4.4 Participants and setting**

Public health in Canada is the shared responsibility of governments at the municipal, provincial/territorial, and federal levels (Fierlbeck, 2010). As such, this study did not set out to restrict the involvement of participants to any one of these levels. However, due to reasons of

feasibility, participants were recruited from only one municipal level (public health units within the Greater Toronto Area) and from only one provincial level (public health departments or agencies at the provincial level in Ontario, who were also located in the Greater Toronto Area), in addition to recruiting participants from the federal level in Canada (who were located in Ottawa).

Key informants were sampled purposively based on their professional positions in order to permit in-depth inquiry into individual perspectives on the topic of interest and from the population of interest (Patton, 2001). The key informants I sought to interview in this study were characterized as public health ‘policy-makers’. In many ways, ‘policy-maker’ is an ill-defined occupation. Indeed, it is often not an explicit title given to anyone working in public health organizations in Canada. While a policy-maker can quite obviously be said to be someone who is responsible for making policy, what it means to ‘make’ or be involved in the ‘making’ of policy is ambiguous at best, and might range from legislators and bureaucrats to researchers involved in the generation and reporting of data for the purposes of policy development. As such, I chose to use the term ‘policy-maker’ in my study to refer not to a precisely defined, homogenous set of individuals who have this title, but rather to a population of interest to my study given their role in developing or implementing policy and practice change in public health organizations or agencies. Because the population I was most keenly interested in interviewing were situated closer to the ‘policy-making’ level rather than the frontline, ‘practice’ level, I chose to use the term ‘policy-maker’ as a shorthand to refer to the more wordy and inelegant ‘individuals involved in policy and practice change’. With that said, in this study I was not interested in interviewing those who may not have familiarity with the public health context (e.g., politicians or other ‘decision-makers’), nor was I particularly interested in interviewing individuals who enact policy through practice but who do not contribute to policy and practice

change primarily in their role (e.g., ‘frontline’ public health nurses, physicians, and so forth).

There is no doubt that interviewing these populations would be insightful and important, but this was beyond the scope of my study.

Key individuals from public health agencies or organizations who have a role in developing or implementing policy and practice change were targeted for recruitment. Because my study was interested in exploring and examining the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health are similar or different, two well-established programmatic areas, or ‘contexts’, of public health were chosen from which participants were recruited: chronic disease prevention and public health emergency preparedness and response. Organizational structures in public health organizations facilitated the identification of key individuals in these areas, as ‘chronic disease prevention’ and ‘public health emergency preparedness and response’ are often departments or divisions in these organizations. As such, ‘directors’, ‘managers’, or ‘chiefs’ (depending on organizational vernacular) of these organizational divisions were typically the first point of contact for recruitment. Government directories and websites were primarily used to identify potential participants (e.g., Government Electronic Directory Services (GEDS)).

My initial interest in this study was not to explore perspectives on social justice in any particular programmatic areas or context(s) of public health policy and practice. Yet, given a lively theoretical debate concerning whether social justice ought to be understood uniquely in different ‘spheres’ or contexts (see Chapter 2), in addition to a gap in the empirical literature regarding this question, I became motivated to explore this by examining and comparing the perspectives of policy-makers in multiple domains of public health policy and practice. This required me to choose (at least) two ‘domains’ or ‘contexts’, which led to a theoretical question of what might constitute a ‘context’ of public health. While I appreciate that public health

‘contexts’ could be conceptualized and demarcated in innumerable ways, for the purposes of this study my decision ultimately rested on a practical justification driven by participant recruitment in conjunction with an acknowledgement of the ways in which different areas of public health are commonly demarcated in practice. First, as mentioned above, ‘chronic disease prevention’ and ‘public health emergency preparedness and response’ are common departments or divisions within public health agencies and units. Aligning my demarcation of ‘programmatic areas’ or ‘contexts’ with these departmental/divisional boundaries facilitated a rather straightforward process of recruiting participants who unambiguously ‘practice’ in these areas. Second, reinforcing this decision is the fact that these divisions correspond to distinct public health programs and services that are often mandated by government. For instance, the Ontario Public Health Standards include chronic disease prevention and public health emergency preparedness and response as two of the five mandatory programmatic areas around which its standards were developed (Government of Ontario, 2008).<sup>2</sup>

Public health emergency preparedness and response was chosen as one of the programmatic areas from which participants were recruited due to the prevalence of musings in the public health and public health ethics literature that this area of policy and practice might operate according to distinct reasoning or decision-making around social justice as compared to what is found in other public health contexts (as described in Chapter 2). I am not aware of any other discussions where social justice has been perceived to be taking on a particular flavour or theoretical leaning in other areas of public health policy and practice. Given that one of my research questions seeks to explore the extent to which distinct perspectives on social justice

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<sup>2</sup> The other programmatic areas being ‘family health’, ‘infectious diseases’, and ‘environmental health’ (Government of Ontario, 2008).

might exist in different programmatic areas of public health, this provided sufficient reason to choose this as a context from which to recruit participants. Chronic disease prevention was selected as a ‘comparator’ programmatic area due to its ostensible distinctiveness from the programmatic area of public health emergency preparedness and response.<sup>3</sup>

Once local contacts were identified, snowball sampling was used to identify additional potential participants involved in policy and practice change in the public health area of interest. In all cases potential participants were contacted via email for recruitment. Because there are few public health organizations at these levels of government and few individuals who may be involved in public health emergency preparedness and response or chronic disease prevention in each organization, the organizations from which participants participated will not be named in order to protect their anonymity. No demographic information was solicited from the participants (e.g., ethnicity, income level, etc.). Participants were provided a \$10.00 gift certificate to a local coffee shop as a token of appreciation at the outset of interviews.

This study received formal ethics approval from the Office of Research Ethics at the University of Toronto and all participants provided written consent prior to participation (see Appendix II for the Research Ethics Board approval letter, Appendix III for the study’s consent form, and Appendix IV for the participant recruitment email).

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<sup>3</sup> ‘Chronic disease prevention’ was considered more readily distinguishable from ‘public health emergency preparedness and response’ as compared to, say, ‘infectious diseases’, which is another programmatic area identified by the Ontario Public Health Standards. ‘Infectious diseases’, for instance, was ruled out as a potential ‘context’ from which participants were recruited given that those working in the area of infectious diseases might very well also work in the area of public health emergency preparedness and response given that infectious disease outbreaks, epidemics, and pandemics are commonly considered to constitute significant public health emergencies.

#### **4.5 Data collection**

Data were collected through qualitative, open-ended, semi-structured interviews. A qualitative design was considered most appropriate to answer my research questions given my interest in exploring and understanding participants' perspectives (Green & Thorogood, 2004). This method of data collection enabled an in-depth exploration and examination of the study's topic of interest, which was important given that the potential content and contours of these interviews were unknown in the absence of prior studies providing any insight in this area (Lincoln & Guba, 1985; Patton, 2001). Indeed, despite the paucity of qualitative research exploring perspectives on social justice, there are frequent calls for using qualitative methods in social justice research (Bernts, d'Anjou, & Houtman, 1992; Giacomini, Hurley, & DeJean, 2014; Sabbagh & Golden, 2007; Törnblom, Jasso, & Vermunt, 2007; Wilson, 2009b). Because this is the first time public health policy-makers were asked about their perspectives on social justice in a research context, this study was intended to be exploratory in nature, which could be better characterized as being poised to generate hypotheses rather than test hypotheses. By engaging individuals through semi-structured interviews, I was able to pursue different ideas, concepts, and paths of inquiry that emerged in the course of interviews, while allowing participants to supply their own topics, ideas, and questions that they felt were relevant to the subject of social justice. Furthermore, due to the interactive nature of interviews, the meanings, explanations, and opinions articulated by participants, in addition to the contexts in which they were discussed, were able to be explored in depth (Brinkmann & Kvale, 2015; Patton, 2001). Acknowledging that multiple factors likely influence perspectives on social justice, this method enabled contextual dimensions to be introduced by participants themselves given their perceived relevance to their perspectives on social justice. Because so little is known about public health policy-makers' perspectives on this

topic, having the opportunity to openly explore paths of inquiry generated by in-depth engagement with participants was considered particularly important.

The semi-structured interview guide itself was developed according to the purposes and structure of what Brinkmann and Kvale (2015) characterize as a ‘conceptual interview’, which seeks to explore meanings and conceptual dimensions of central terms, and ‘chart’ participants’ conceptions of phenomena, like social justice. The guide was developed in consultation with my thesis committee and vetted with two additional researchers with expertise in qualitative interviewing in the area of public health ethics. The guide was developed with the principal aim of ensuring a similar line of inquiry was taken with all participants, while maintaining some freedom to “build a conversation” by shaping questions relative to answers provided by participants (Patton, 2001, p. 343). The interview guide incorporated questions that explicitly inquired about participants’ perspectives on the concept and role of social justice in the context of their practice, as well as questions that asked participants to speak freely in voicing their opinions, values, and judgments about the goals and scope of their domain of public health practice in order to explore participants’ “interpretive processes” (Patton, 2001, p. 350). Ultimately, two interview guides were created—one for participants involved in public health emergency preparedness and response and one for participants involved in chronic disease prevention—but differed only slightly in terms of the language used in reference to each programmatic area (see Appendix V for the interview guides).

My interview technique consisted of a funnel-shaped approach to exploring this study’s topic of interest (Brinkmann & Kvale, 2015). I began interviews by asking general questions about participants’ work and their organizational role, the goals of their work, and what they are trying to achieve in the area of public health in which they work. It was only after establishing some context of the participants’ work, role, and area of public health practice that the topic of

social justice was broached. Approaching the topic in this way was important for two reasons. First, it allowed for the establishment of the context in which a discussion of social justice could be situated. Second, because explicit discussions of values or theoretical concepts may not have been commonplace for participants (e.g., discussing something in their context of public health practice they considered to be ‘unjust’), approaching interviews in this way helped to establish an interpersonal relationship and context upon which more ‘challenging’ discussions could proceed.

Interviews were conducted between March, 2014 and January, 2015. Recruitment of participants ceased when thematic saturation was reached within the data; that is, when new data no longer shed any further light on the issue under investigation (Guest, Bunce, & Johnson, 2006; Mason, 2010; Sandelowski, 1995). Twenty interviews were conducted in total, with ten participants from the area of chronic disease prevention (three at the federal level, three at the provincial level, and four at the municipal level) and ten participants from the area of public health emergency preparedness and response (three at the federal level, four at the provincial level, and three at the municipal level). I conducted all interviews. Beyond those who participated, two individuals declined to participate, providing no reason for their choice. Participants tended to have the title of ‘director’, ‘manager’, or ‘chief’, half were physicians by training, and fourteen were female and six were male. The interviews ranged from thirty minutes to eighty minutes in length, with an average and median interview length of sixty minutes. Each interview was conducted either in person or over the telephone. Interview locations and dates of the interviews were at the discretion of the participant. Interviews were audio recorded and were transcribed verbatim by a professional qualitative research transcriptionist. I verified all transcripts provided by the transcriptionist by reading the transcript while listening to the associated audio file.

#### 4.6 Data analysis

The process by which data were analyzed aligns most closely with Braun and Clarke's (2006) method of 'thematic analysis', which is a method for identifying, analyzing, and reporting patterns or themes within data. The recursive process and phases of thematic analysis followed in this study are described below, and are briefly presented in the following table reproduced from Braun and Clarke (2006):

Table 1: Braun and Clarke's (2006) 'Phases of thematic analysis'

Phase	Description of the process
1. <i>Familiarizing yourself with your data</i>	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. <i>Generating initial codes</i>	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. <i>Searching for themes</i>	Collecting codes into potential themes, gathering all data relevant to each potential theme.
4. <i>Reviewing themes</i>	Checking if the themes work in relation to the coded extracts...and the entire data set..., generating a thematic 'map' of the analysis.
5. <i>Defining and naming themes</i>	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. <i>Producing the report</i>	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

I was the sole participant involved in data analysis. Data analysis began by familiarizing myself with the data. This involved reading and re-reading each transcript to get a sense of the data corpus. This allowed me to become immersed in the data in order to become familiar with its depth and breadth, which contributed to the rigour of my analysis (Green et al., 2007). During this phase, memos were written that comprised initial analytic ideas. Much of the data was quite

familiar to me prior to this stage given my involvement in data collection and transcript verification.

Following this stage, I began to generate initial codes for each interview. Codes “‘identify a feature of the data...that appears interesting...and refer[s] to ‘the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon’” (Braun & Clarke, 2006, p. 88). The generation of codes was largely data-driven and was conducted with the aim of characterizing the words and ideas used in the data as descriptively as possible. Data management was facilitated by NVivo qualitative data management and analysis software.

Similar codes and similarly coded extracts were then collated in order to explore and identify potential themes within the data. Themes were actively identified if they captured something important or of interest in relation to this study’s research questions, empirical background, and theoretical background (Braun & Clarke, 2006). Themes were therefore constructed both inductively based on the descriptive codes, allowing analysis dimensions to ‘emerge’ from codes identified in the data, and deductively, based on the interpretive apparatus of this study. The generation of themes was achieved, in part, by conducting a ‘theoretical reading’ of transcripts and codes (Brinkmann & Kvale, 2015). This meant that this study’s theoretical background ‘sensitized’ my analysis, suggesting ‘directions in which to look’, which can be contrasted with the theoretical background being ‘definitive’, which ‘defines what there is to see’ (Brinkmann & Kvale, 2015; Strauss & Corbin, 1998). In other words, theory influenced the analytic process when it ‘earned’ its way into the study. Ultimately, this ‘theoretical reading’ meant sustaining a “creative dialogue between different theories in the data, in a quest not to validate any presumed perspective, but simply to understand the problems in their social context”

(Hargreaves, 1994, p. 122).<sup>4</sup> Theory was considered to have ‘fit’ the data well when it “easily permit[ted] comparison to its major components, when it provide[d] a useful framework for organizing the data for re-presentation, and when it [did] not distort the meaning of the data” (Sandelowski, 1993, p. 216). Using this study’s theoretical background as a ‘sensitizing’ analytic apparatus ultimately allowed the theoretical dimensions to be analytically identified while allowing themes to retain their unique contextual features. Finally, relationships between codes and between emerging themes were also explored to identify what could be characterized as ‘overarching’ themes and ‘subthemes’. Once themes were identified, all codes and their data extracts were collected that fell under each theme.

Once a set of candidate themes were identified they were reviewed in order to explore whether they could be combined, refined, or separated according to whether data within themes cohered together meaningfully and if identifiable distinctions between themes remained. Each coded data extract within a theme was reviewed in order to discern whether it ‘fit’ the pattern. Then, each theme was reviewed in relation to the data corpus in order to (a) capture codes or data not included in any theme, and (b) explore how the themes related to each other, how they were ‘situated’ within the data corpus, and how they ‘fit’ with other themes (e.g., the degree to which themes overlapped). Ultimately, each theme was interrogated in relation to the specific objectives and research questions of this study.

Next, I named each theme, which involved an examination of the ‘essence’ of what each theme was about, the aspect of the data that each theme captured, what I found interesting about each theme, and how it aided in answering this study’s research questions.

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<sup>4</sup> Recall the quote that opened this chapter: “...conceptions of justice make sense only when *placed in their appropriate social contexts*” (Miller, 2001, p. 111).

At all phases of analysis, detailed notes were kept that identified which codes were added, removed, or collapsed, in order to establish an ‘audit trail’ (Lincoln & Guba, 1985). Trustworthiness of data analysis was ensured through standard qualitative criteria such as prolonged engagement with the data (Lincoln & Guba, 1985). The quality and rigour of this analysis was further preserved by adhering, as best as possible, to Braun and Clarke’s (2006) criteria for good thematic analysis, which is reproduced here:

Table 2: Braun and Clarke’s (2006) ‘15-point checklist of criteria for good thematic analysis’

<b>Process</b>	<b>Criteria</b>
<i>Transcription</i>	The data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the tapes [recordings] for ‘accuracy’.
<i>Coding</i>	Each data item has been given equal attention in the coding process.
	Themes have not been generated from a few vivid examples (an anecdotal approach), but instead the coding process has been thorough, inclusive and comprehensive.
	All relevant extracts for all each theme have been collated.
	Themes have been checked against each other and back to the original data set.
	Themes are internally coherent, consistent, and distinctive.
<i>Analysis</i>	Data have been analysed—interpreted, made sense of—rather than just paraphrased or described.
	Analysis and data match each other—the extracts illustrate the analytic claims.
	Analysis tells a convincing and well-organized story about the data and topic.
	A good balance between analytic narrative and illustrative extracts is provided.
<i>Overall</i>	Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over-lightly.
<i>Written report</i>	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	There is a good fit between what you claim you do, and what you show you have done—i.e., described method and reported analysis are consistent.

The primary objective that motivated my approach to data analysis was to elucidate the ways in which participants talked about the concept and role of social justice. This can be contrasted with, for example, the objective of capturing the ‘actual’ or ‘authentic’ behaviours, beliefs,

meanings, or experiences of participants—the so-called ‘facts’ of what participants think— as static, measurable entities (Potter & Wetherall, 1987).<sup>5</sup> I consider the responses that participants supplied to interview questions to be ‘discursive’ accounts rather than what might otherwise be considered descriptive reports of experiences or ‘facts’ about how they think or behave. As a result, participants’ perspectives were not judged as more or less ‘authentic’, ‘accurate’, or ‘unbiased’ descriptions of their ‘reality’.

#### 4.7 Conclusion

This chapter presented an overview of the methodology and methods used in this study. The study involved qualitative, semi-structured interviews with public health policy-makers, which were conducted in order to answer my first and second research questions, and an analysis of these interviews in light of this study’s theoretical background to answer my third and fourth research questions. In the next chapter, I present the findings from my interviews.

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<sup>5</sup> The latter would, of course, not align with my rejection of positivistic axioms.

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## Chapter 5 Findings

*“Yeah, of course we support that, but what does it actually look like in practice?”*

- Study participant

This chapter describes the findings from my qualitative interviews. The themes presented here speak to the ways in which the public health policy-makers I interviewed talked about social justice and shed light on the discursive role that different features and considerations of social justice played as situated within the participants’ context of public health practice. The findings presented in this chapter respond to this study’s first two research questions by describing public health policy-makers’ perspectives on social justice and the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health are similar or different. While the findings described here necessarily involved analysis and interpretation on my part (as discussed in the previous chapter), Chapter 6 provides a refined analysis of these findings and seeks to respond more directly to this study’s third and fourth research questions.

In the following I did not set out to separately describe findings according to the two programmatic areas of public health in which my study’s participants practiced; however, the themes generated in each participant ‘group’ (chronic disease prevention and public health emergency preparedness and response) differed in key ways, and were thematized and presented accordingly.<sup>1</sup> This, of course, is an important finding that speaks directly to my second research

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<sup>1</sup> Upon reflection it seems that this is advantageous, as it nicely facilitates a context-situated reading of participants’ perspectives.

question regarding the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health are similar or different. However, this is not to say there were no overarching themes identified in the data corpus. As such, overarching themes will be described, as will the unique themes identified in what might be called the two ‘data sets’ that correspond to the two programmatic areas of public health in which participants practiced.

Three key themes emerged from interviews with participants involved in the programmatic area of public health emergency preparedness and response (PHEPR): (1) the goal of ‘restoring the norm’; (2) targeting the ‘most’ as constitutive of the ‘public health approach’; and (3) the milieu of justice: vulnerable populations, resiliency, and access. Three key themes emerged from interviews with participants involved in the programmatic area of chronic disease prevention (CDP): (1) understanding the ‘who’: taking differences between populations into account; (2) targeting the ‘right’ population(s); and (3) health equity as a ‘safe’ alternative to social justice. Two key themes were identified from across the data corpus: (1) the unclear meaning and operationalization of social justice; and (2) the prominence of ‘equity’ as a term representing justice-based considerations.

In the description of themes, data extracts are presented in order to illustrate the ways in which themes are supported by the data. Extracts were chosen according to their ‘aptness’ in illustrating the nature of the theme discussed. Each extract includes an identifier, which acts to contextualize the quote: the first three characters (e.g., ‘P08’) refer to the participants’ numerical identifier (e.g., participant number eight), the second set of characters (either ‘CDP’ or ‘PHEPR’) indicate the area of public health practice in which the participant worked (chronic disease prevention or public health emergency preparedness and response, respectively), and the third set of characters (‘M’, ‘P’, or ‘F’) indicate the level at which they worked (municipal, provincial, or federal, respectively). In some instances, data extracts are presented that include

not just quotes from participants but also include my interaction with participants. In these instances, participants' voices are prefaced by a 'P' at the beginning of quotes (to represent 'participant'), and my voice is prefaced by an 'I' (to represent 'interviewer').

## 5.1 Overarching themes from the data corpus

### *5.1.1 The unclear meaning and operationalization of social justice*

As indicated in this study's interview guide, at one point participants were asked to tell me what they took the term 'social justice' to mean. In response to this question, and elsewhere in the course of interviews, participants communicated their uncertainty regarding the term's definition:

I can't give you a textbook definition of social justice, so I am going to slightly skate around that. (P07-CDP-P)

Is justice the same as social justice? Is justice through the courts and police, is that justice? Or is social justice some other term? (P08-PHEPR-M)

There's no one answer to that, what is health equity, what is social justice. (P10-CDP-P)

Participants often sought my personal definition of social justice so that we would have a working definition upon which to base our conversations:

I probably should've asked you this up front unless you, unless you have to, you'll throw it back in my... (Laughter). What's your definition of social justice? (P02-PHEPR-P)

Can I ask you, um, what you see, what you define as social justice? (P19-CDP-F)

As illustrated in Chapter 2, coming up with a singular, straightforward definition of social justice is a difficult task. Thus, this uncertainty should not be considered a peculiarity of my findings.

Even when situated within the context of their work in public health, though, participants were either still unclear about how social justice should be interpreted, or otherwise expressed that the term does not confer a specific meaning:

To me it's [saying 'we have a commitment to social justice'] the same thing as we should all eat locally: these are normative motherhood statements and I don't know what they mean in [public health emergency] response. (P08-PHEPR-M)

In terms of, like, in science, folks find them [the concepts of social justice and equity] very soft and fuzzy, right? (P14-PHEPR-F)

We collect the data and the piece that we're missing is to be looking at it through a social justice lens, and what, you know, what, what does that mean? (P16-CDP-M)

Using the words justice, equity, or fairness is usually as far as that conversation goes. It doesn't usually, in my experience, it hasn't gotten beyond just using those words and to what do those words actually mean. (P01-PHEPR-M)

Depending on how you define social justice, then you would say, well, what are the outcome indicators of social justice that we should be including? Um, that's not really my field of expertise, so, I have a bit of a research background so it makes me uncomfortable to say, well, these are the indicators that we should evaluate. So, I couldn't say without more of a conversation of what should be within that realm of what is social justice, in terms of what to measure. (P19-CDP-F)

P: The problem is that I'm not sure it's been operationalized in a way that makes it practical. So, it's fine to say that it's a social, it's a value, it's an important value, uh, for example, inclusion, or, um, empowerment, there's a whole bunch of them, but in terms of defining what that actually means and, for example, I don't have the competencies in front of me [referring to the Public Health Agency of Canada core competencies], but I don't recall there being competencies, specific competencies, outlined for what that would mean from social justice.

I: No, it doesn't. Yeah.

P: So that's where what I mean about operationalization. So we can say, like, from a motherhood statement, yeah this is important and it should guide people's work. What does that mean in terms of the competencies that people, that practitioners should have, policy-makers should have, related to social justice? That's not clear. So that's where there's a lot of room for, well, yeah, of course we support that, but what does it actually look like in practice? Or what does it look like in our processes? (P19-CDP-F)

Despite acknowledging that social justice is included as a central value in their organizational practice (e.g., that it is included in the Public Health Agency of Canada's (PHAC) core competency statement for the practice of public health), some participants appeared perplexed, if not incredulous, when asked to discuss how this value translates into their practice:

I: I was wondering what you take that concept to mean for your practice. If you were to interpret that value in the core competency statement, what meaning does that have for you?

P: Um, man you're tough. You're a tough nut to crack. Holy crap. What does that mean in my personal practice.... (P20-CDP-F)

I was kind of surprised by it [seeing the term social justice in the PHAC core competency statement], I have to tell you. So, I had to kind of go and look it up. (P18-CDP-M)

I: If you were to try to measure how you're doing in terms of whether you're promoting or achieving social justice in your work, what would you want to measure or assess?

P: Oh gosh... (Laughter). I don't know (Laughter), that's some, Max, actually (Laughter) that's a mind boggling one (Laughter).... (P05-PHEPR-F)

These responses are not surprising to me, as there is no doubt that these were difficult questions to answer; however, I did not consider them unreasonable given the ubiquity of the term in the literature and the importance bestowed to it in documents like the Public Health Agency of Canada's core competency statement. The difficulty that participants generally displayed in providing answers to these direct questions was anticipated, so participants' perspectives on social justice were explored in a rather less direct manner through other interview questions. While this meant participants' perspectives on the meaning and role of social justice were not necessarily going to be captured in one or two sentences provided in response to an explicit question about the term's definition, I believe a more comprehensive idea of participants' perspectives on the 'meaning' and role of social justice emerges from a reading of the other themes presented in this chapter.

Participants indicated that a substantial reason *why* the meaning of social justice was unclear to them is because the concept by its very nature means different things to different people, which may further indicate that participants did not think there *is* or *can be* a clear, singular meaning of social justice:

I'd say social justice is not, um, I mean I, I think it's a term that means many different things to different people. (P03-PHEPR-P)

Everyone has a different conception of what it actually means. (P03-PHEPR-P)

It's really interesting...I find from country to country and culture to culture that, you know, uh, around ethical principles and how, how you know, we sort of have a language, um, that we use, but really, culturally, I think they have very different meanings sometimes. (P14-PHEPR-F)

They are also very personally held things. They seem to be very personally held value and belief systems. It's not things, um, these are not, uh, necessarily things that people feel, um, free and open to talk about. (P14-PHEPR-F)

That's the crux of the matter, isn't it? Because, anybody who, if you ask everybody who works in public health what their commitment to social justice and health equity or whatever is, they would probably, uh, you'd probably get, like, a hundred or more different definitions of that, right? (P10-CDP-P)

I think talking about social justice becomes...people glaze over for some reason. Maybe it's because everyone has a different idea of what it means. You know? (P13-CDP-P)

You all mean, like, something different by the term, right, and so, so until you come together and we say, okay, this is what we are talking about, and, you know, so I think sometimes that's the problem. (P16-CDP-M)

### *5.1.2 The prominence of 'equity' as a term representing justice-based considerations*

This uncertainty or lack of clarity surrounding the meaning of social justice was often juxtaposed by participants raising the term 'equity', which they suggested is 'clearer'. Participants raised the term equity throughout interviews, even in direct response to my questions about social

justice, which indicates to me that participants considered there to be a relationship between the two terms.

You can hear what I'm saying about social justice and having some conceptual lack of clarity about that, so I could speak more to health equity but perhaps not social justice. (P19-CDP-F)

I'd say equity, you know, the answer to your question is that equity is clear to me. Social justice, I think the definitions are fuzzy. (P03-PHEPR-P)

I am trying to think if I ever had a conversation about social justice, so whether that means everyone I work with equates them [social justice and equity] or whether it is just, it is considered in a different, it's just different, it's not about (Long pause), it's just not, yeah, I don't know to be honest. (P04-PHEPR-P)

It was unsurprising to me that there was a general lack of clarity regarding the meaning of social justice once it was made evident that social justice is generally not perceived to be explicitly part of the discourse of participants' daily work in public health:

Nobody raises the term... Nobody talks about social justice. (P01-PHEPR-M)

Those words social justice or fairness would never come up...In local public health, they're implicit. (P01-PHEPR-M)

I mean it's, it is really interesting because I don't think we've had a conversation about social justice since I have been here. (P04-PHEPR-P)

We talk about equity but we don't, we, we don't talk about social justice. (P04-PHEPR-P)

I don't know if I would use that exact word [social justice] *per se*. (P09-PHEPR-M)

I don't hear the term social justice, um, that specific term, what I am hearing more and more is that talking about, um, health inequalities and health inequities. (P16-CDP-M)

I have never seen the term social justice come up in any of the sort of inquiries or conversations. It's, it doesn't seem to be permeating the conversation. (P16-CDP-M)

It's just not a term that we use, you know, what I mean, like, a lot. (P18-CDP-M)

Generally, apart from the aboriginal file, I don't hear people talking about social justice at all. (P13-CDP-P)

This had rather far-reaching implications for how the subject matter was discussed in the remainder of each interview. For instance, when participants were asked to recall something in their public health work that they would consider to be 'unjust', or perhaps something that, to them, reflected an attempt to 'achieve' social justice, participants provided responses but often reverted to speaking about inequities and equity without addressing the fact that the question was about social justice. Overall, participants generally appeared to have a greater comfort in speaking in terms of equity and inequities rather than social justice and injustice. As will be illustrated later, though, while my findings support the idea that participants considered social justice and equity to be related, when prompted, they believed the two terms referred to different things and used different terms and ideas when discussing each concept. The meanings and roles attributed to these terms are described in more detail within other themes presented in this chapter.

## **5.2 Themes unique to interviews with participants involved in public health emergency preparedness and response**

### *5.2.1 The goal of 'restoring the norm'*

As described in the previous chapter, my interviews with participants began by discussing the context of their work in public health. As indicated in the study's interview guide, this involved asking participants to describe what they believe public health emergency preparedness and response is attempting or aiming to achieve—what its purpose or principal goals are. This worked to situate later discussions about social justice in the particular context of participants'

work and area of public health practice, which permitted a reflection on how the value of social justice ‘fits’ or is ‘used’ within this context.

Central to participants’ discussions of the scope, role, and goals of public health emergency preparedness and response was the idea of ‘restoring the norm’. Participants characterized public health emergencies as ‘events’ or ‘incidents’ that act as ‘acute’ ‘perturbations’ of the baseline norm of the population’s health, which require a public health response that must occur with some ‘immediacy’. Infectious disease outbreaks or epidemics, like severe acute respiratory syndrome (SARS), were commonly discussed as examples of ‘quintessential’ public health emergencies. The goal, then, of public health emergency preparedness and response, is to ‘restore the norm’—return to the state preceding the perturbation—often as quickly as possible:

The big picture goal would be, we have a certain baseline of functioning, of morbidity and mortality...a disaster or an outbreak or whatever it is, a deviation from that norm, and the purpose, the goal would be to restore that norm...bringing it back to a level that is generally considered the same baseline that we came from beforehand. (P01-PHEPR-M)

You should be able to bring normalcy, some degree of normalcy, back into a community or a household, um, you know, within a short period of time. (P06-PHEPR-P)

It’s about getting to a goal which is getting back to normal... (P08-PHEPR-M)

This idea of the ‘norm’ or ‘normal’ is returned to at the end of section 5.2.

Participants indicated that ‘restoring the norm’ requires, or is linked to, the goal of minimizing morbidity and mortality associated with public health emergencies, which was otherwise characterized as ‘saving lives’:

Our main business, bottom line: save lives. Secondary business is, of course, reduce morbidity. Um, third, make people a little more comfortable perhaps

(Laughing). But, uh, the idea is to reduce morbidity, mortality, uh, associated with an event that can create life threatening situations. (P05-PHEPR-F)

We should be responding to it [a public health emergency] such that we minimize, in that order, morbidity, mortality, and social disruption. (P01-PHEPR-M)

I would say the main goal is to minimize the extent of harm that comes to members of the public from various types of emergency events, and, and to ensure that the recovery is as rapid as possible, um, and so, and to minimize the harm from a, for public health from a population perspective. (P03-PHEPR-P)

Public health, it's, you know, how do you get things done and, and the bottom line is how do you save lives. (P04-PHEPR-P)

### *5.2.2 Targeting the 'most' as constitutive of the 'public health approach'*

These goals expressed by participants—restoring the norm and minimizing morbidity and mortality—were commonly accompanied by words like the 'most', the 'greatest', and the 'greater', which were used in relation to those at which benefits are aimed and intended:

What is the health status of the population? Where does the need seem to be the greatest, um, and where can we actually have, you know, tangible, uh, benefit at a population health level? Like, where is the most benefit we can have? (P09-PHEPR-M)

There isn't enough to go around, and some are never going to get it. That was that, about that debate for the prophylactic as opposed to...but in any emergency, at some point there will be not enough of something, and, and medical services will triage according to the way that they often...it's to, you know, about the, the one that can be saved and, and the greatest good, you know? (P08-PHEPR-M)

We know that population x isn't going to be served by our program, um, so, um, but we have to implement that program for the greater good. (P14-PHEPR-F)

Some of it's based on modelling and, and various, and values, but some of it's based on, you know, again, what's, what's the, the construct of what's, you know, keeping the most people alive and keeping the most people out of trouble. (P02-PHEPR-P)

The preparedness and response has to be primarily focused on, um, on the health of the population as a whole, and ensuring that there's the most benefit to the most people that your interventions allow. (P02-PHEPR-P)

Often emergency planning and, uh, emergency management is, uh, directed at the mean, right? (P14-PHEPR-F)

Some of the extracts above reflect a general ‘given’ of public health emergencies that emerged in interviews: that ‘there isn’t enough to go around’ and not everyone can or will be able to benefit from public health emergency preparedness and response activities due to the fact that, by definition, public health emergencies exceed existing public health capacities required to address them. More will be said shortly about the ‘givens’ in this data.

For some participants, ideas of the ‘most’ or ‘greatest’ were explicitly linked with the idea of social justice:

If there's no concept of social justice, then, um, in some ways, and maybe equity's probably the better paradigm for this, um, you know, it changes your whole response to any mass casualty, potential mass casualty event. In first responder school, from the area that I came, your whole approach to a mass casualty incident is different than your approach to an individual... When you see an individual, the first thing you do is check the individual, um, you know, for a pulse, and do whatever you can before you go to the next individual. In a multi-casualty incident, the first person there is not supposed to touch anybody. They are supposed to survey the scene, figure out how much, uh, help they need, um, and start assessing people very quickly who can be triaged which way, so, who doesn't need immediate assistance, who does need immediate assistance, and who ultimately needs no assistance. So, it's that, it's certainly a concept of equity and, and um, using your resources to save the most people, simply put. Is that social justice? I would say it is. (P02-PHEPR-P)

Framing the goals of public health emergency preparedness and response in terms of benefiting ‘the most’ or generating ‘the greatest good’ was often described as integral to, if not synonymous with, what was described by participants as the ‘public health approach’. Participants discussed this approach as one that takes into consideration, and targets, the *entire* population when preparing for and responding to public health emergencies, and that successes and failures of

public health emergency preparedness and response are contingent upon how well the population as a whole fares.

Because we are population focused in public health, um, uh, our quote-unquote patient is the population, not the individual, and, uh, and it's always possible that some individuals will fall through the cracks. But the goal is, is, um, is basically the welfare of the group. (P05-PHEPR-F)

If you just take hypertension, high blood pressure in the population, there are people who think that the goal should be, focus on the people with the worst high blood pressure, find out who they are, identify them, treat them, and you'll bring the whole curve down. And other people who say we need to take a public health approach, we need to focus on everybody in the population to bring that whole curve downwards for all those people. (P01-PHEPR-M)

We have to develop materials that speak to the broadest part of, of the populous. So, you end up developing guidance that will influence or guide practice in, um, large urban centres at the risk of, of, of not having it, uh, guidance that's relevant to rural and remote areas in as timely a fashion. We run the risk of having guidance that's relevant to our large, densely populated provinces that is not terribly useful for our lesser populated provinces or territories. So yeah, uh, you know, it's, it's a matter of time and, and resources and, and having to, uh, having to, uh, invest maximally, um, you know, where you are going to get the, the maximal impact, but knowing, knowing that there are needs that are, are very, um, valid that are going unmet because you don't have the resources to cover them all equally in, in equal depths, in equal time. So things evolve such that broad guidance comes out early, but things that are really needed perhaps more intensely, uh, intense, intensely needed by a more vulnerable populations have to wait in line, um, until, until you get the other stuff out the door. (P14-PHEPR-F)

P: In some cases the welfare of the group is more important than the welfare of the individual...case in point, we have laws that allow us to, um, to isolate people who have active tuberculosis against their will. You can't run, you can't refuse to take your medicine and run around. You can refuse to take your medicine but we're going to lock you up (Laughter) and, and you are not going to be allowed to run around and spread the disease.

I: So, do you, do you think that sentiment, the, the welfare of the larger group, may be more salient in the public health emergency context?

P: I do. (P05-PHEPR-F)

Sometimes, participants used the word 'utilitarian' in the context of these discussions:

When you're preparing for it [a public health emergency] and drafting plans and making mission statements, that's the time to put in this stuff [considerations of social justice] where you have time for reflection. Most of the time when emergencies happen you'll use some of those mission statements and that, but what often happens is there's a, a focus on, you know, what are we going to do that is, you know, it's a real utilitarian sort of thing. (P01-PHEPR-M)

The concept of social justice for a population and an individual, the concept is the same, I mean, it, again, if you, um, if you look at it through, to some extent as we do in public health, a utilitarian lens, uh, the concept's the same, but the application is much different because of the circumstance. (P02-PHEPR-P)

In a public health emergency there may be, uh, I could imagine scenarios in which you might have one vulnerable population that is small and you cannot meet their needs and you have another larger vulnerable population that you can, but you can't do both. So, I could imagine that kind of scenario where from a strictly utilitarian perspective, you've got limited resources and limited time to respond, you may choose to allow a disparity to even widen from one group while you try to achieve the best possible outcomes for the larger. (P03-PHEPR-P)

I interpreted the way in which participants characterized this 'public health approach'—the way public health operates, at least when discussing public health emergency preparedness and response—to be indicative of what participants considered to be the 'givens' of the 'goings on' of this programmatic area. That is, it was as if the goals and scope of public health emergency preparedness and response described above were considered by participants to be necessitated by the circumstances of public health emergencies, such as conditions of scarcity. This was evident as well when interviews moved from discussing the goals of public health emergency preparedness and response to the role of social justice in this context:

I: Do you think the nature of public health emergencies and the goals we discussed of public health emergency preparedness and response makes it more or less difficult to satisfy that 'commitment to social justice'?

P: It's more difficult in that the situation is more acute. There's almost always going to be more people involved. When there's more people involved there are more diverse opinions about things, number one. And more importantly than that, there's just no time for discussing those diverse opinions because it's just usually a bit of a, you, it's a, it's putting out fires. (P01-PHEPR-M)

To go back though to your scenario, where it's a large scale significant event, like a tornado, in those cases I'd love to be able to tell you, oh yeah, there's a lot of triaging that goes on, but in the initial aftermath of that particular tornado sometimes it's just who's, who's, you know, who's there? And, we're just, we're pulling people out. (P06-PHEPR-P)

They [the public] just, you know, they just want you to pick up the garbage. Social justice has nothing to do with it, you know, so, (Laughter) uh, and same thing with this, they don't, they just want the power on and they want you to pick up the debris. (P08-PHEPR-M)

I think we can probably do better in the emergency front, because we, we tend to be about impact and, and dealing with impacts of the events [Um hmm], as opposed to then specifically thinking about equity issues. (P11-PHEPR-F)

Public health emergencies were described in such a way that seemed to necessitate particular activities, which appeared to border on being self-evident due to the acute, urgent nature of emergencies. *Just* 'putting out fires', 'pulling people out', and 'picking up the debris' were expressed as self-evident activities that are necessitated by public health emergencies.

Importantly, it seemed that this left little room for considerations or other goals falling outside of these necessitated activities. Indeed, in some cases participants made it explicit that thinking about social justice would act as a constraint on accomplishing these aims:

For emergencies, to actually measure it [social justice], or to put metrics in our plans that would oblige us to do things to measure it and to respond to that during those plans, I think there are probably so many, I think it's, in principle an important thing to say, but in practice is going to be, there are so many moving points at that time that putting that extra constraint on may, I mean it may or may not be, and it really depends on the situation, a real impediment, perhaps. (P01-PHEPR-M)

If focusing on those ideas would be, would, or would be perceived to take away resources from managing the overall issue, whatever it would be, let's say an epidemic, then, then it's just, you know, that's just not going to be on the agenda. (P01-PHEPR-M)

I don't think you can say 'that's okay' [the creation of a disparity in health outcomes due to a public health emergency intervention]. It's not okay, um, but we have to live with it because, you know? (P14-PHEPR-F)

It wasn't malicious, like, well, 'the hell with them!' You know, it was, 'we've got a flood, we have got to get these people the heck out of dodge, and let's do it quickly'. (P06-PHEPR-P)

Interestingly, this notion was similarly raised among participants working in the area of chronic disease prevention if public health emergency preparedness and response arose in the course of those interviews:

At the practice level, a lot of the work that's done in communicable disease and environmental health is protocol based: people just, you know, go through step one to, like it's protocols and algorithms largely and there's, it's harder to apply health equity impact assessments and that sort of thing. It's not impossible by any stretch and I have certainly talked a few people through applying it, to like a bed bug program and other stuff. But when it comes to the bed bug program, they are like, okay, well, um, I am a public health inspector and I am told to go into this home that has been identified to public health as having a bed bug issue and I do A, B, C, D, E, F, G, right, and what's the health equity issue, right? Like, the people that might be poor, they might be rich, whatever. Like, what do you, what do you want me to do about this health equity thing? And same with an outbreak, right? And the outbreak thing, it's just whoever happens to get sick, right? (P10-CDP-P)

The idea of just 'getting things done' to respond to a public health emergency was also reflected in the idea expressed by participants of just 'doing the best you can' given the nature of public health emergencies, which, in the following extract, includes a significant degree of uncertainty:

When SARS first started we didn't know what the hell it was, and we didn't know, um, you know, we began to see cases and we did not, we, we suspected it was viral but we didn't know the virus...and so, in those uncertainties we, um, the Toronto folks asked people to go into self-quarantine. Anybody who had contact or thought they had contact with somebody, and there were so many of them that you can't put a policeman on everybody's door, we asked people to self-monitor themselves. You make kind of a blanket, uh, blanket decision like that. You don't say, you're not in a position, you don't have the information to say, well, if you were actually at the bedside you should quarantine yourself but if you were in the living room don't worry about it. Okay, you just don't know that, so you say *anybody* (Laughter), right? Is that unjust or unfair? I don't know. I think it's, I think it's a, I didn't, I wouldn't characterize that as unjust and unfair to the people

that might have gone into quarantine unnecessarily, but you, since you can't, you don't have the information to, um, make a more refined decision, you, um, you basically have to go with something broader. I don't see that as unjust or unfair it's just you do the best you can. (P05-PHEPR-F)

Part of this tension between 'just getting things done' in public health emergency preparedness and response, as necessitated by the nature of public health emergencies themselves, and the possible 'constraint' imposed by thinking about or acting in accordance with social justice, also emerged as a tension between acting in accordance with what was perceived as 'science' and acting in accordance with what was perceived as 'social justice' (a mutually exclusive consideration).

If science doesn't even trump everything, um, in decisions, then, why should social justice? It's easy for me as a, you know, I see myself as a principled human being, saying that it should, but the reality is, you know, what are the prices you pay? So, how high a price do you pay for social justice? And, what are the unintended consequences of that price, because then there's a downstream lack of social justice because you don't have the money to pay for something else. (P02-PHEPR-P)

The H1N1, um, and, you know, there we were prioritizing groups of people to receive vaccine, do you recall? But as I recall those were, those were based on, on the prioritization criteria, were based, uh, not so much on equity and, and um, but, but based more on a practicality and science. For example, if we were to have a severe, severe, uh, situation like the 1918 flu with bodies on the street, you know, you need to maintain order. So, the practicality was, okay, we will put the policeman and fireman up at the top of the list, or, you know, the top of the list not because they, socially, they, they were, they were somehow better than everybody else...So, I mean, it was along those lines, you know, that in my experience public health thinking went more along those lines than they did along, uh, considerations of social justice. (P05-PHEPR-F)

Decisions on vaccines, and how the ethical dimensions—which is where I think about social justice probably more, although I mean they are linked— but, um, uh, are not really prominent compared to the kind of technical ones. (P04-PHEPR-P)

The degree to which social justice is a consideration external or secondary to the primary goals and ‘goings on’ of public health emergency preparedness and response was expressed in a unique manner by one participant:

I think it’s foolhardy for public health to go off trying to reduce, uh, wage inequities when there’s still you know, outbreaks of measles happening in this province. (P03-PHEPR-P)

This particular participant suggested that ‘social justice’ considerations in public health concern the reduction of wage inequities, given how wage inequities implicate poor population health (“everything really comes back to distribution of wealth in our society” (P03-PHEPR-P)). I interpret the above sentiment to mean that the nature of public health emergencies, like infectious disease outbreaks, must be addressed (and be considered ‘primary’) before public health seeks to address ‘social injustices’, like wage inequities, that may ultimately impact population health. That is, the priority function of public health was perceived to be the management of emergent threats and downstream effects—controlling outbreaks and ‘putting out fires’. The upshot of this perspective was stated by this participant in the following way:

I think there are significant issues around equity related to the outbreaks of measles that public health could be working on, so it’s not to say I am not, we shouldn’t deal with that, and, and there are many vulnerable populations that don’t have appropriate levels of immunization and we are working on that, but the, the bigger picture social justice that we are going to solve world poverty, uh, I, I think if public health people want to do that than they should go work in ministries of finance. (P03-PHEPR-P)

### *5.2.3 The milieu of justice: Vulnerable populations, resiliency, and access*

Both ‘restoring the norm’ and ‘minimizing morbidity and mortality’ are goals that, to me, invoke the *active* role to be played by professionals in public health emergency preparedness and response. A related term—that of ‘resiliency’—was discussed by participants as a characteristic

of *populations* that *enables* the norm to be restored. Resiliency is something that participants indicated must be ‘created’ or ‘built’ for individuals and communities; something that must be supported through preparedness and targeted interventions for those who are less able to ‘return to normal’ on their own.

Everything we do to prepare and mitigate, respond, is to create resiliency...it’s the old idea of being, getting up faster when you get knocked down. (P08-PHEPR-M)

It’s building individual community and provincial resilience...Our job is to make it bounce back to what it was once—a spring— as opposed to some, just, you know, a mash of, uh, twisted wire...what I am trying to do is build the resilience so we can bounce back as quickly as possible. (P06-PHEPR-P)

This framing—or dimension—of ‘restoring the norm’ is where participants’ attention was predominantly focused towards the considerations and role of social justice in public health emergency preparedness and response. Because some populations are less resilient to public health emergencies than others, participants expressed that special attention may need to be paid to ensure they are able to recover from public health emergencies. This was seen as a consideration of justice. In particular, participants used the term ‘vulnerable’ in reference to those populations who may be less resilient to a public health emergency—those who have special needs that must be addressed in order to create resilience.

It [public health emergency preparedness and response] has to be equitably distributed, whatever that means. But in my mind, personally, it means those who don't have the resources, um, to be able to be as resilient as others. (P02-PHEPR-P)

I don’t think that they [those in public health emergency preparedness and response] think of equity specifically, that’s what comes across the front of their minds, but buried in the, the immediate reaction I think, um, is the need to look after those vulnerable populations. (P11-PHEPR-F)

Your community bouncing back, is for you, your vision of that, of that community returning to normalcy, does it have everybody there? The folks with special

needs, with disabilities, are they a part of your community? I am of the mind that when we talk about resilience it's resilience of the entire community. (P06-PHEPR-P)

This is for all emergencies. It's the, the people that, for whatever reasons, the event causes them to be vulnerable. Our ability to, to identify them, and try to, uh, overcome their barriers to access existing services...but it is not about, I am not improving their life and I am not changing their, their life that they had today, I am just trying to get them the support that they ought, that they normally would, whatever, they had, so that they can, can get through the event. (P08-PHEPR-M)

I think it [public health emergency preparedness and response] would focus on the amount of, uh, the treatment of our most vulnerable people. I think there is a theme in there that the, that the level of support meets our concepts of, uh, (Long pause) you know, justice and dignity. (P08-PHEPR-M)

I think it, you know the values of social justice I think embodies the notion that, um, although each individual is equal to other, to each other individual, each individual also has the right to be as, um, uh, in the context of an emergency, um, has the right to have the same chance at a good outcome as anybody else. So that means that, that we in public health need to work hard at, uh, leveling an uneven playing field...So, as an example...people who don't have a lot of family supports may have less access to antiviral, antivirals. (P02-PHEPR-P)

The focus on vulnerable populations to enhance resilience can be contrasted with those who may be well-positioned to recover from a public health emergency. A social injustice obtains when only the 'affluent' are 'protected' and can recover from a public health emergency:

So there's bound to be, you know, a lack of social justice, because who is going to get, who is going to be in the best protected areas? Generally it's going to be more affluent people who's going to have resources to, the insurance, the everything else, to be able to recover. It's going to be people with money. (P04-PHEPR-P)

As alluded to in the above extracts, participants suggested that the central *means* by which the resilience of vulnerable populations can be supported is through improving their access to public health services during a public health emergency. The ability of vulnerable populations to access

public health services or resources during a public health emergency was considered to be a metric of 'success' in the domain of social justice/equity:

I think the metric would be more about the service level for those that, uh, and their ability to access services. (P08-PHEPR-M)

We pay a lot more attention to remote and isolated communities for example because we are worried about differential access. (P11-PHEPR-F)

A difference in, in the access indicator would clearly indicate that somehow your response hadn't, uh, achieved equity. (P03-PHEPR-P)

How we as part of that community can, uh, better respond and adapt to extreme heat events, and one of the things that we do think about is how do we make sure, you know, that people who are particularly vulnerable to heat because of pre-existing, uh, medical conditions or, um, socioeconomic, uh, you know, elements, whatever it is, how do we make sure that that they are provided, that, one, they are aware of what's happening and, two, that they are provided with access to cooling stations or water, or that they are able to get medical assistance, um, quickly if that's what's required? (P09-PHEPR-M)

Another means that participants suggested is important in supporting vulnerable populations during public health emergencies is consultation. This was directly tied to considerations of justice: if no efforts were made to understand the special needs of vulnerable populations, populations would be less resilient and an injustice would obtain.

The level of engagement that you could have with, um, with vulnerable groups or special populations, um, if you are engaging with, with those groups, um, I think that, that is an indicator that at least the effort is being undertaken. (P14-PHEPR-F)

P: If the decision-makers weren't able to, uh, demonstrate a, um, defensible process that led them to that decision that, that disadvantaged that population, they would have a claim [to injustice].

I: Right. And so, even, so if that did occur and there were, say that group still did fare worse, however it was implemented...

P: They wouldn't have a claim.

I: They wouldn't have a claim?

P: Even if, in retrospect, the decision was wrong...I think that we made the best decision we could based on the information at the time. And, had the outcome been bad, it's, I don't want to say it's too bad, but it is too bad. (Laughter)

I: But not unjust?

P: Right.

I: It's just too bad?

P: Right. Correct. (P02-PHEPR-P)

One participant went so far as to suggest this procedural, consultative approach is the *only* practicable manner in which considerations of social justice can be incorporated in public health emergency preparedness and response:

I: In your experience is that how the commitment to social justice plays out?

P: I mean unless you have a philosopher king, you have to do it that way. (P02-PHEPR-P)

As indicated in Chapter 2, one might consider there to be a tension between focusing on vulnerable populations and the (previously described) goals of public health emergency preparedness and response to 'save the most lives' and create the 'greatest good for the greatest number'. Indeed, theoretically, there is a possibility that focusing resources on improving the resilience of vulnerable populations could impede the goal of saving the most lives possible. This tension was variably acknowledged by study participants with some discussion of how the two aims co-exist or interact. The justice-based considerations of focusing on vulnerable populations were discussed as being attended to largely in terms of *preparedness*:

So, I think they're, the mitigation prevention might be a way because then programs deal with these, these issues of equity, access, at the front end in a non-crisis way...There's always room for improvement, but I think, I think that the, the, uh, the justice issues are really at the beginning. (P08-PHEPR-M)

P: Attawapiskat, as you can imagine, is a community, for example, that is going to be struck by any issues, any emergencies, um, disproportionate to anyone else. So, um, I think, I think as people repatriate to those communities they really do

need to think about, well, how do we prevent this repeating itself over and over again...

I: So, the social justice aspect then comes more into play maybe in the prevention and recovery, uh, considerations?

P: Probably, possibly the preparedness as well, and certainly in response I would say that it's probably less. (P11-PHEPR-F)

If *unprepared*, then this focus on vulnerable populations may be neglected altogether:

As people develop their plans they have already built these things [consideration of special needs]. So, when they are doing it, so what happens, though, is, when it's a large scale sometimes where people are unprepared then it's the last, it's the path of least resistance. (P06-PHEPR-M)

While this particular participant did not specify, I interpret this last sentiment to be 'the path of least resistance' *to achieve the self-evident goals of public health emergency preparedness and response*. Justice-based considerations related to the needs of vulnerable populations and bolstering their resilience by ensuring they have access to public health services were largely considered to be present (or perhaps most effective) in the prevention or preparedness stages of public health emergency preparedness and response, whereas the response phase was largely described as operating according to the self-evident goals of saving the most lives and restoring the norm as quickly as possible, while eschewing explicit considerations of 'social justice' in order to not constrain these goals. If the particular needs of vulnerable populations were not adequately addressed in public health emergency preparedness, then there may be a greater likelihood their needs will go unaddressed in public health emergency response.

### 5.2.1a *The role of the 'normal' in contextualizing extraordinary circumstances*

This final theme returns to the initial discussion of 'restoring the norm'. As such, I would characterize this as a sub-theme of the first theme, but have chosen to present it here so that it

can be understood in the context of themes 5.2.2 and 5.2.3. As previously highlighted, public health emergencies were characterized by participants as acute perturbations to a particular baseline in the public's health. The role of that 'normal'—the state from which the perturbation occurred and the state towards which public health emergency preparedness and response activities are principally aiming to restore—also appeared to influence, or be invoked in relation to (or in contrast to), how social justice was conceptualized in the context of public health emergency preparedness and response:

The first question is not whether social justice and equity are relevant in public health emergency response, it's whether social justice and equity are relevant in, uh, the way our society is structured and services are rendered by government, or whatever, in general. So, if they're not terribly important every day, why are they all of a sudden important in public health emergency response? It's hard to imagine why it would suddenly become important if it wasn't important all the time...If you're in a situation where you have a difference in equity to begin with and nobody seems to be much focused on it, it's hard to imagine why you would focus on it in an emergency unless that difference was heightened in the extreme. Now, if they're not important in general because we have a perfectly or nearly perfect, perfectly equitable society, and that equity is going to be shattered by some kind of event, then the, then you'll have those who might say we should focus on equity because that's the perturbation in the baseline, or you have those who say no we're not going to focus on equity, we're going to just try to bring everybody up. (P01-PHEPR-M)

Fundamentally, life is unfair. (Laughter) And, um, and the fact that, I mean it's already unfair in the scheme that someone has, um, someone is in a position where they are going to be disadvantaged, right? That's already unfair. So, um, yeah. Life ain't fair they tell me. (P14-PHEPR-F)

I think the best example is, again, who to resuscitate. Is that, you know, if you go into an emergency department, um, and you've been bashed up in a car accident and you need fifty units of blood, um, on any day of the year, you'll get that. Um, but if you're coming in the middle of a pandemic or in the middle of a mass casualty incident, where, you know, if they take that fifty units of blood and they can save twenty-five people and let you die, or I should say let me die, let's uh...(Laughter)...they'll do that. (P02-PHEPR-P)

The interview from which the above quote was extracted then moved on to explore this idea further—to explore if and how the concept of justice may be distinguished in a public health emergency where there is a deviation from the ‘normal’:

The concept of social justice for a population and an individual, the concept is the same, I mean, it, again, if you, um, if you look at it through, to some extent as we do in public health, a utilitarian lens, uh, the concept's the same, but the application is much different because of the circumstance...Is it fair that because I'm in my sixties I might not get the same treatment as somebody in their twenties, um, because of some protocol? Uh, not fair to me. But it might be fair to my society. (P02-PHEPR-P)

This passage raises an idea of shifting the focus of justice from individual welfare (and fairness) to population welfare (and fairness) during a public health emergency. It is ‘because of the circumstance’—the emergency—that the concern of justice must be what is ‘fair to society’ rather than what is ‘fair to the individual’.

Interestingly, one participant raised a justice-based concern related to providing care or supports during a public health emergency that exceed an individual’s ‘normal’—where providing care during a public health emergency that exceeds a level of care or support that does not exist in an individual’s normal, knowing they will ultimately return to their ‘normal’, could be considered ‘unfair’. The example raised by the participant to illustrate this idea, who works at the federal level, was that of responding to a public health emergency in another aid-dependent country:

Different governments have different perspectives on how to do things as well. The US for example, they airlifted people out of Haiti [during the 2010 earthquake] and treated them in the United States, which wasn’t an approach that Canada had necessarily taken. Unless you are in there for the long term and, um, if you take someone out of that environment and give them the best care and the most, um, state of the art prosthetic limb, for example, you better be there for life. You can’t just throw them back into chaos, so, those are some of the considerations I think of...foreign affairs and other, um, policy-makers, even

though many Canadians were ready to take people in, you have to think the longer term in terms of what's fair. And that's a bit of a weird way of thinking about it. For example, you know, because in their normal environment they don't get this level of care, is it just to lift them out of that environment and give them the best of care? That might be just but should you throw them back in afterwards? That seems unjust, um, and you might as well think about giving them a visa and a passport and keep them. (P11-PHEPR-F)

This idea is reflected and is particularly salient in one of the quotes by a different participant referenced earlier:

Our ability to, to identify them [vulnerable populations], and try to, uh, overcome their barriers to access existing services...but it is not about, I am not improving their life and I am not changing their, their life that they had today, I am just trying to get them the support that they ought, that they normally would, whatever, they had, so that they can, can get through the event. (P08-PHEPR-M)

All of this is to characterize a sub-theme that ran through discussions with these participants involved in public health emergency preparedness and response, which is that the 'normal' appears to play a role in thinking about the parameters and goals of public health emergency preparedness and response, and that it even appears to permeate and shape considerations related to social justice. Importantly, throughout these discussions participants spoke about the 'norms'—the background or baseline circumstances—upon which public health emergency preparedness and response operates when a perturbation in those circumstances occurs. As is evident in the quote where the example of the Haitian earthquake is raised, there may be an assessment of justice in the response—by airlifting individuals out of an area experiencing a public health emergency—but a distinct assessment of justice in this context concerns the treatment of individuals in relation to their 'normal'—what was their normal and how can we (or should we) return them to their normal?

These three themes illustrate participants' perspectives that public health emergencies are a deviation from the 'normal', which is accompanied by 'givens' about what needs to get done: to save lives, and do so in such a way that is aimed at the 'populous', the 'mean', the 'greatest good', and restore the norm as quickly as possible. Justice-based considerations are not absent; they attune the attention of public health emergency preparedness and response to those vulnerable populations who may lack access to important supports required to restore their norm. However, these supports, while important, were largely not discussed as part of the 'goals' of public health emergency preparedness and response. Rather, they were raised as external considerations that modified the goals of public health emergency preparedness and response, which sometimes put the two in tension. In some cases, justice-based considerations were discussed as constraints on the 'goings on' of public health emergency preparedness and response.

### **5.3 Themes unique to interviews with participants involved in chronic disease prevention**

#### *5.3.1 Understanding the 'who': taking differences between populations into account*

Central to discussions with participants involved in chronic disease prevention was the idea of 'unique' populations and words like 'difference', 'disparity', 'discrepancies', and 'segments'; that the nature of participants' work in public health involves taking into account the uniqueness of populations and the differences between population groups:

The way that I sort of interpret that [the idea of a 'commitment to social justice'], and I think manifest it in the work that we do is, you know, being conscious of the fact that public health interventions, there's no, there's no one size fits all, and that acknowledging that the data shows that there are populations, like some populations within Canada that are disproportionately affected by certain chronic diseases, certain common risk factors...What you obviously want to do is try not to exacerbate sort of any of these differences that may exist within these

populations...You just need to be really clear on what those differences are so that you maximize the impact. (P12-CDP-F)

P: I will say that from an interventions perspective there are still not a lot of evaluation of interventions to indicate whether they have differential impacts on population groups.

I: Right.

P: So, do they work better for men or women? Some of that is reported. Do they work better for different income groups? Very rarely is that analyzed or reported. Do they work better for different ethnic groups? Also very rarely studied. Rural versus urban, all of those kinds of things, so, um, we've recently developed criteria to identify health equity sensitive interventions so that we can flag these. (P19-CDP-F)

The other thing that I'm very sensitized to is gender. Period. Because I worked in a previous life, I worked setting up a centre for men's health, and while, you know, talking about men's health is not popular from an equity point of view, because, you know, males are seen to be the dominant. (P13-CDP-P)

There are definitely populations within Toronto that, that have a, you know, a disproportionate burden of the illness right, of the actual disease and, you know, if we want to step back and look at really getting a better handle on those populations, uh, most at risk for developing diabetes, and we know who they are, right? We just need to find out where they are so, you know, when, when we were starting to deliberate and kind of do our needs assessment and really look at, you know, where are those populations in Toronto, how can we best, uh, outreach and work together and tap into, uh, you know, many assets in those communities and, and really take a, a finite number of resources and really work with those communities in a meaningful way so that we, we, kind of work with them before they actually have developed diabetes. And yet we work with them because they are at a disproportionately higher risk, okay? (P17-CDP-M)

One participant succinctly summed up this theme regarding capturing and attending to the unique characteristics of different populations through chronic disease prevention activities:

P: Why have we not been really collecting much more data around uh, you know, ethnicity, around, uh, you know, uh, length of time in Canada, around really understanding, uh, the, the populations that we work with, you know, that's, that socioeconomic demographic data.

I: So, it's understanding...

P: The who.

I: Okay.

P: I think that's really critical to understand the who. (P17-CDP-M)

In some cases, the discussion of attending to unique populations would manifest as a perceived need to focus on identifiable population groups:

I think the examples in a way for me are more about what we didn't think of. Or like, the omissions. So, a really top of mind example there is the aboriginal world, because our [division of public health organization] has the aboriginal health [subdivision] and I was the acting manager of that for a little while and so I learned a lot. And, what happens is that we don't have good data on aboriginal people. There is some data in certain pockets, but like, in terms of like, good across the board data, it's not there. And so, so when we plan programs, we're not thinking, you know, we don't have that built in, you know, and so you'll, like, diabetes is a good example. I mean, diabetes is a huge problem for aboriginal people. And yet, you know, when we're planning around the Ontario diabetes strategy, we have to keep trying to remember we need a component here for aboriginal people. You know? And so, you kind of go, this is just wrong, like, this should just be, like, it should be second nature. There should be systems and there should be data, you know, it shouldn't always be an afterthought. So I think that's a really big problem in terms of how aboriginal people are treated. (P13-CDP-P)

Operating with explicit attention and sensitivity towards the differences between population groups was directly linked to the 'social justice perspective'. In other words, social justice considerations were seen as embedded in the 'goings-on' of chronic disease prevention.

A social justice perspective has to take into consideration multiple population groups. (P19-CDP-F)

If one wants to talk about, um, you know, social interventions, just what we were just talking about, or even a policy change, um, you need evidence to inform that policy change and that's where my work could come in. So, while it might not be directly, you know, um, in this example, a core competency *per se*, the evidence that we're putting out is, um, to be used to inform, um, you know, certain social justice principles and values. And by that I mean something like, um, you know, advocating for particular change, or, or particular intervention, um, hopefully something that takes into account, um, social discrepancies, um, that speaks to how prevention or correction in these discrepancies can be leveraged or can be addressed. (P20-CDP-F)

There's common risk factors to all of these things [chronic diseases], right? Um, and it becomes more of a, um, a systemic, systems issue sort of. There are just naturally right now in our situation families that have more and families that have

less and, and, um, you know, you look at people who are struggling to survive with part-time incomes, like, there's those other constructs that are sort of out of our realm that we can't control that make it a challenge for some individuals to, to benefit the same way as others in the lifestyles that they have before them. So, it just seemed more like it's, it's generally a consideration in all of the work that we do. (P15-CDP-M)

I feel my kind of compassion and commitment for social justice, I think to myself, Max, if we're not working on the margins I have always felt this in public health and yet I've over my career have gone through periods where I felt a real kind of...the way I was being asked to work and, and really where my value base takes me in public health. Um, that I think if we're not working on the margins that is social injustice in my mind. (P17-CDP-M)

People aren't talking about it by way of social justice, but I think we talk about it or at least we, we are, our work in, in surveillance is more reflective of the distribution of  $x$ , whatever  $x$  might be, it could be, you know, health, it could be obesity, or it could be positive mental health, or mental illness, or diabetes or whatever, but it's distribution among people in particular places in time, right? So person, place, time, what is the distribution of whatever it is you're looking for as your outcome measure? So in the sense, if there are discrepancies and there usually are, whether it's between people or across time by way of trends, or um, geographically, um, then that is something that's our bread and butter. Like, we do that. You know? On a routine basis. (P20-CDP-F)

The idea that these social justice considerations constitute the 'bread and butter' of chronic disease prevention was most explicitly expressed by one participant in the following manner:

I think that public health is actually underscored by those kinds of principles. That's the, really, that's why I like working in public health, because it has, it actually has a moral foundation, and in my opinion, without being able to give you, except very descriptively, a definition of social justice, social justice is a principle, it's kind of a moral, it's a moral foundation of public health. It absolutely is, yeah. (P07-CDP-P)

Returning back to the notion of the 'who', participants talked specifically about the 'who' in reference to those at 'greatest risk', those who have the 'greatest needs', or those who are 'disadvantaged':

The program [screening program] is designed to support families who have greater risk. (P07-CDP-P)

I think, just based on a principle, uh, people want to do good, you know, and public health wants to do good, and public health wants to serve those with the greatest need. (P10-CDP-P)

How do we, uh, you know, really meet some of the highest need? (P16-CDP-M)

Because, you know, they will come out and say that, that for, you know, social determinants, it's income, it's housing, you know, all those things are, you know, important, that in some of our areas, you know, the greatest need...So, how do we alter our services to sort of suit the needs of those, you know, who are of the highest need? (P16-CDP-M)

We talked about the need for both the, the decision was both the outcome of the decision was fair in terms of the distribution, and I don't mean fair as being equal, fair as being proportionate to need in essence, but also that the procedure was fair and included those individuals in the decision, so I think we need both. (P07-CDP-P)

We need to set this up in disadvantaged communities first. That's important. Um, so they are bringing in concepts of equity right from the beginning. (P07-CDP-P)

We know that it will help the advantaged more than it will help the disadvantaged proportionately. So, can we at least from a program perspective look and see how this program is going to, um, identify target populations or populations in need? (P18-CDP-M)

Ultimately, the 'greatest needs' or 'disadvantage' was interpreted in the context of the social determinants of health, which was directly linked with the idea of social justice.

P: It's a universal program, but it's less likely to be accessed by those who are, you know, impacted by structural determinants of health. This is really an interesting dilemma because they can access it in a sense that the program is equally offered, so it's equally available. But their access to the program is less, they access it less because of all of those kind of upstream determinants, um, you know, understanding, awareness, transportation, um, (Long pause) um, sort of social/physical context right? Racial and ethnic context. So there's, there's so much going on, so is it unfair and unjust their access to the program? Um, I've got to think about that...

I: So, I mean...

P: What's unfair and unjust is that they are in that position in the first place. (P07-CDP-P)

I will say that it's clear that there are health disparities, in health, in health behaviours, and in health outcomes across, within Canada, across different population groups, and that there is social disadvantage, be it based on ethnicity, um, in some cases based on gender, uh, geography, and, uh, socioeconomic status. So, that's clear from surveillance and research across the country that those disparities in health exist. Is that unfair? Yes, I think it is unfair that everyone can't have the same kind of health. (P19-CDP-F)

### *5.3.2 Targeting the 'right' population(s)*

Identifying and understanding the 'who' was ultimately seen as necessary because this helps to identify the 'right' populations to target by public health activities:

From our standpoint, like, our mandate is squarely sort of within health, and so, we look at the data and the data says, yeah, in these populations they are faring worse than, say, the general public, and therefore what that requires is more of a, um, I guess a targeted approach. (P12-CDP-F)

A lot of people want to, uh, like it, correctly I think, public health is, you know, about universalism and universal programming and population health but we tend to do a lot of targeting which tends to be based on sort of social determinants of health or lack of access. (P10-CDP-P)

We know that our mandate is to provide, um, sort of a population health approach, right, a universal approach. But within that what we are now doing is saying, okay, so we might have that as a standard service but how do we then focus on those key population areas that are in, have the greatest need, right, for our services? And then how do we adapt our services to meet them? (P16-CDP-M)

We know that it [universal programs] will help the advantaged more than it will help the disadvantaged proportionately. So, can we at least from a program perspective look and see how this program is going to, um, identify target populations or populations in need. (P18-CDP-M)

There is a lot of debate to say that, you know, a good chunk of our efforts...are not targeted to the right people, or the right approaches, in order to address underlying conditions. (P19-CDP-F)

What is particularly interesting about the above extracts is an apparent defense of the ‘targeted’ approach against the ‘public health approach’, which was discussed as being ‘universal’ by its very nature. The presumed focus on the *entire* population as constitutive of the ‘public health approach’ also emerged in interviews with participants involved in public health emergency preparedness and response. Yet, in interviews with participants involved in chronic disease prevention, the ‘universal’ approach was not merely described as being augmented with attempts to ensure vulnerable populations are not being entirely missed or left out. Rather, particular populations were described as being explicitly identified and targeted as a central aim. In fact, discussions of targeting the ‘right’ populations were accompanied by discussions of ensuring that the ‘wrong’ populations do not benefit, as this would not help in narrowing the disparity between the two groups:

This [chronic disease prevention program] was actually targeting the right population at the beginning, but over time it shifted and it became more accessed by people who are already doing well. So, that’s just an example of a slippage and...so, the question really becomes, if the policy-makers and the researchers really believe that this program needs to be targeted, how do they put some ring fences around that, okay? So, the, what’s the mitigation? Although it was intended to be accessed by people who were less well-off, it’s now being accessed by people who are better off. Um, how important is this, that we ring fence it and keep it for those who are least well-off...So, if it’s [a school nutrition program] set up in a school which we know is just in a disadvantaged neighbourhood, then having a policy that, that actually sort of prevents cross boundary migration...Which is then equitable. (P07-CDP-P)

For example, they look at something like the fitness tax credit that was meant to encourage more people, um, to get involved with recreation and sport. And in the end it benefits more people in the upper economic band, but the intent was to get, you know, uh, so there’s things that are done with good faith but sometimes they actually don’t enhance and maybe create a little bit more disparity. So, it’s a challenge. (P15-CDP-M)

Some of the staff had kind of thought, well, you know, we need to do this, we need to go out with this kind food skills programming across Toronto. We need to make sure that our service delivery areas all get, let’s say, program x. Okay, and when this planning process was undertaken, um, it became quite apparent that

there would be communities, uh, in Toronto that actually would get no programming because they were not a community who had a higher risk of developing diabetes over and above the average population, right? And some of the staff said, ‘but that’s unjust, that’s unjust, every, that’s, you know, that’s not fair, you know? Every taxpayer in Toronto—we are a public service—every taxpayer should have access to the same level of service, right?’ So, what we needed to do, Max, is help staff understand that the most, that we would actually be doing *more* of an injustice to be, kind of, um, distributing these, these resources so that every community got the same amount whether they needed it or not. (P17-CDP-M)

That was really the injustice because, by doing that [taking a universal approach], we were not recognizing that there were certain populations at much higher risk...Not everybody needs the same, so it’s that conversation between equity, you know, between inequality and inequity, and what’s, and how do we begin to, to narrow the gap or, or lower the gradient, or whatever sort of analogy you want to use. You don’t do that by kind of treating everybody as if they’re the same...that’s what it means to, to actually have a strong health equity framework to our work. (P17-CDP-M)

Participants discussed the importance of understanding the ‘needs’ of populations and being responsive to those needs. This responsiveness to population needs was seen as central to an ‘equitable’ approach:

What we are trying to do is, how do we bring that, um, health equity lens down to our program levels? I think we need to get better at assessing each one of our clients, our, our geographic areas in, in what is the need? (P16-CDP-M)

This concept of social justice really, or injustice in this case, really speaks to me about how we need to really remember what we are here trying to do and that we need to listen to and respond to the voices in our community and as best as we can understand them we need to, um, I think we lose connect sometimes so I think this just keeps it and, you know, the truth and the heart of the matter and what we are trying to achieve. (P15-CDP-M)

We do have, um, an, an infrastructure priority here for ethno-cultural diversity, is one way that we have tried to land on how can we be more equitable in our approach and really understand our community. (P15-CDP-M)

Those programs are guided by the Ontario Public Health Standards, uh, although as you can appreciate, Max, um, you know, uh, operationalizing those provincial standards in a large urban setting like Toronto means that we absolutely need to

uh, to, uh, nuance many of those programs and services so that they're, they are relevant uh, to the needs of our very diverse community. (P17-CDP-M)

### *5.3.3 Health equity as a 'safe' alternative to social justice*

Participants spent considerable time discussing the distinction between health equity and social justice, what each term meant to them, and the role each idea plays in their work. Participants used words like 'proximal', 'neutral', and 'quantifiable' to describe equity:

It [equity] feels more proximal. It feels more neutral. It feels more, uh, quantifiable, uh, quantifiable, okay? Whereas getting, moving from the discussion about health equity to unfair and unjust to talking about justice, to talking about social justice, requires that personal confrontation and unpacking about what are my biases, what am I not comfortable with, how do I feel about certain things, that some people don't have the time or the inclination to do, okay? So that's where I think the conversation needs to deepen on the difference between health equity and social justice. (P07-CDP-P)

P: I think talking about social justice becomes...people glaze over for some reason. Maybe it's because everyone has a different idea of what it means. You know? Maybe it's because it hasn't been...like, the term equity has been beaten to death for some reason.

I: So why has that worked so well?

P: I don't know. I don't know. Maybe is it because, like, equity can be counted. Right? Because you can, like, you can count some dimension of equity. Like, social justice seems to have a little more qualitative feel. You know? Maybe we live in a world where, if you can't count it, it's hard to understand it. (P13-CDP-P)

This sentiment was also raised by a participant involved in public health emergency preparedness and response:

For some reason equity to me seems almost (Long pause) a little bit more, uh, objective or quantifiable, or more easily described, whereas social justice, to me, is, is a much broader, softer concept, um, but more all-encompassing. (P14-PHEPR-F)

Participants contrasted the 'comfortable', 'quantifiable', 'proximal' nature of health equity with social justice, which was characterized as concerning '-isms' (e.g., 'racism', 'sexism',

‘colonialism’) and ‘deeper’ ‘political’ and ‘structural’ issues. Participants indicated that discussing social justice would take their work in a very different place than health equity:

A social justice impact assessment would actually get to the very deep issues of social justice, like, um, racism, colonialism, (Long pause) there’s probably other ‘-isms’ that I should be listing here that I am not, those are the first two that come to mind, um, I guess those structural determinants as opposed to social determinants. I think that’s what it would likely get into. (P10-CDP-P)

You would have to go deeper and actually ask them [public health professionals] about some of the ‘-isms’, or you would have to, to try and understand that, I think that, I think that’s where you would have to go. (P07-CDP-P)

What’s the social justice impact of housing policy, of daycare policy? Let me tell you that will, that will take the conversation in a, in a different direction, I believe, in a deeper, richer direction, than just, uh, and I don’t mean just, but, than simply talking about health equity or inequity. (P17-CDP-M)

They [a public health organization] noted that they have this big gap in their services around aboriginal clients and they specifically did something about it. Is that improving health equity? Maybe, maybe, but it just goes right back to wondering, well, what exactly is health equity? Does that make any difference to social justice? I don’t think so. Because the structural things you haven’t changed at all. (P10-CDP-P)

There may be other indicators of social justice that are beyond [health]. Um, just as an example, like income and education, and social supports, there could be a lot more, that’s about involvement or about decision-making or about other aspects that, about power, um, that might not be covered just by looking at health equity. (P19-CDP-F)

These distinguishing considerations of social justice were characterized by a couple of participants as a concern for the ‘why’:

P: But I think a lot of it is...like, we can all agree to the principles. Most of us anyway. We do have an economist in our midst, which is an interesting, always an interesting perspective. But, I think where people get stuck is that there isn’t a very good understanding, at least within [the public health organization], it’s not top of mind as to *why* you have differences in outcomes according to income, or according to ethnicity, or things like that.

I: And that why matters?

P: And the why is key to the whole thing. In a deeper...in a deeper way. (P13-CDP-P)

And then also get into the whys, so why do you think this is the case? You would have to with more, if you are going to actually explore this in public health. (P07-CDP-P)

For participants, these distinct foci of health equity and social justice have practical implications.

For instance, participants suggested that health equity focuses attention, and ultimately flavours the scope of 'inequities', towards 'superficial', 'materialistic' things rather than the 'deeply embedded' challenges that are more situated within the domain of social justice:

P: [sarcastically asking] Why do we have to focus on, you know, STI incidents in gay men, because they have got really high income? Okay? So this is, like, exactly the sort of the, the, the immediate reaction is, it's [health equity] about income. It's a materialistic interpretation of inequity rather than an understanding of sort of deeply embedded, um, sort of cultural or structural or other kinds of norms.

I: Do you think that, the deeply embedded in the '-isms' like you talk about, is that more the domain of social justice?

P: Yes, yes, and that's where, that's why I think that it's almost easier to talk about health equity. (P07-CDP-P)

A health equity impact assessment is, is more comfortable for people because it's most likely going to focus on the materialistic kind of determinants and the, and the view of health equity, a materialistic view of health equity...They ['most people'] totally think about health equity around disability access, basically, like ramps. It comes up more than you might expect...around the materialistic perspective of equity where it's all about income and education, and it's not about like racism and gendered stuff and, you know, more (Long pause) harder to get your head around that concept. (P10-CDP-P)

This 'superficial' focus of health equity was reflected in participants' discussions of the way in which health equity considerations interact with or are implemented through public health activities: at the level of public health programming.

Many people understand health equity in terms of equal access to services, that understanding is like, or they might say equitable access to services. So it's

*services, access...* That's where the conversation moves to being about health equity to about social justice, okay? That's the neat thing for me, when it gets to there. Whereas I think when we talk about health equity we're often talking about, you know, a very shallow thinking about access to resources, access to health care. (P07-CDP-P)

Within Toronto you're serving, I am totally making this up, but, you know, your parenting program might serve 600 clients a year. Now, you've gone from 2 aboriginals to 50 aboriginals in a population of I don't know how many urban aboriginals, but more than 50. Like, you know, like, have you actually increased health equity? Like, probably, but a lot? I am not sure. At the level of the program, yes, right? Because now your services are perhaps more equitable, you've definitely identified a gap and filled it, so at the level of the program you've done a lot of good work. But I don't think when people say improve health equity that's what they mean, right? (P10-CDP-P)

We've been doing, um, a fair bit of work in the area of safe injection sites, right? And, um, if, if you want to talk about kind of social justice issues and the fact that, um, you know, uh, the kinds of policy, federal policies that are being put in place that by their very nature are creating injustices in society, right? Now, I could take a very different approach, um, so if you look at the, the bill passed federally around the kind of hoops that one would have to go through to open a safe injection site, right? Um, so I think to myself, if we just looked at that on the surface of, okay, how, what kinds of services can we offer right now within, within public health services? Okay, so we're out doing needle exchange and all of that. Um, that to me is an attempt to look at health inequities, right? We know the populations who are most at risk who need our services. We, you know, we look at all the areas that will encourage access to our methadone programs and our needle exchange programs, and all of that, but yet, we also need to really look at the, the policies, federally and even provincially that perpetuate social injustice. (P17-CDP-M)

This idea that health equity operates primarily at the programming level was also expressed by a participant involved in public health emergency preparedness and response:

I think public health can point out challenges related to social justice, but I am not sure it can actually solve them. Whereas public health is in a position to deal with equity in terms of access. (P03-PHEPR-P)

This focus on public health programming can be contrasted with where it is that participants considered to be the primary focus of social justice considerations, which was characterized as

being in the realm of the ‘political’. In this context, participants discussed the associated constraints related to thinking about social justice:

I see social justice certainly as the, the political piece of equity, and that’s perhaps just my interpretation, but I look at social justice more in terms of that piece and I look at equity much along the things of, so, what’s equitable in terms of programs and services, more of the softer side. (P18-CDP-M)

P: It could be that the priorities of the intervention and also the political, however you want to use that, small p, big p, um, obligations and mandates of organizations, so they’re mandated to show that health knowledge is increasing, health skills or behaviours are changing, then their focus, their outcomes they’re looking for are changes in that.

I: Right. Right.

P: They may not be looking at changes in conditions, changes in intermediate indicators in between a program and its ultimate outcome. And so, their bottom line is to show we implemented *x* number of programs and reached *y* number of people, um, and that’s what their success is measured on, and it may not be that they changed *x* number of policies or *x* number of settings in these ways that will change the environment for health. (P19-CDP-F)

Part of this depends on sort of your own political milieu where you work. Do you have a separate board of health, do you have a political system, do you report to a political board of health? Uh, we, you know, we do not have a separate board of health. Our politicians are our board of health, so sometimes there are, uh, well what should we say, *constraints*, sometimes there are political sensitivities around the degree of advocacy one can proceed with though, so therefore on some matters, you know, you might then go more to looking at more from a program perspective...social justice, which I, I certainly, probably I would say, well not probably, I would say that we’re not, we’re not there yet as a health unit. I mean, we are still looking at the equity piece and part of it is political constraint (P18-CDP-M)

I think in an ideal world that’s what we should strive for, but reality bites, right? And, so, you do have, um, you know, politics that come into play. (P20-CDP-F)

[for health equity] I don’t have to hand over all of my power, whereas if I actually wanted to deal with the structural determinants of health and colonialism and racism and all of that, I am probably going to have to give up a significant amount of my power and I don’t think the politicians are going to go for that...And, and to have me in my privileged position making all of these decisions based on my assumptions about those who are less privileged is not the right way to do things, but it is the way to, it is, it is the way things are done because then I am going to come to conclusions—this is the collective ‘I’—that are comfortable for those that are in power and who are, are the more privileged class, right? Um, and nobody

wants, like, that's, uh, I mean I don't know what you said handing over the health equity impact assessment and I am like, oh, I don't want to do that, maybe that's because I just want to hold onto my power, maybe that's just how we are, right? We don't want to, if we wanted to turn our whole society upside down and hand all the power over (Laughter), I don't think that's going to happen, but that, in that, that's where social justice starts to go, right? Which is where health equity is much more comfortable because it's like, it's like just about health, it's like, I can keep my power but I want to reduce your diabetes, right? And, and I am okay with that. (P10-CDP-P)

The foregoing extracts allude to the putatively divisive nature of social justice, which is contrasted with the 'neutral', 'comfortable' nature of health equity. Some participants suggested that health equity is an 'easier' way in which to discuss these justice-based considerations:

Health equity for us is a lot easier to sell. (P18-CDP-M)

There is a very strong reaction to the word social justice. (P10-CDP-P)

Whereas getting, moving from the discussion about health equity to unfair and unjust to talking about justice, to talking about social justice, requires that personal confrontation and unpacking about what are my biases, what am I not comfortable with, how do I feel about certain things, that some people don't have the time or the inclination to do, okay? (P07-CDP-P)

Because we all like to simplify our lives, right? And, and if we can boil it down to income, well that's easy, you know? (Laughter) Like we, we, we *get* money, um, but not many of us really understand what it's like to experience racism, right? So, it's harder for us to kind of really be able to manage those concepts. (P10-CDP-P)

Interestingly, one participant talked about how some considerations are in fact 'safe' and can therefore be discussed in practice, whereas other 'social justice' considerations are too divisive to be discussed:

Talk about racism in here? Are you kidding? (P13-CDP-P)

Institutional racism leads to people not going to the doctor. You know? And so, these things are very real, too, and to me that's social justice, right? But, not in here. (P13-CDP-P)

One of the things that the [particular program] has done is said, every research proposal that comes in must have a gender lens. Okay. So that's there. But, is there a social justice lens? Is there even a broader equity lens? Not yet. You know, so gender's *safe*. Like, even though I would argue it's still not done and there's social justice issues in gender, and it's still not done properly, but it's a little more safe. LGBTQRS whatever, you know, that's becoming, yeah, we can talk about this. (P13-CDP-P)

The aboriginal example, I think for me, you know, helps bring social justice more to life. So, the way I think of that is, you know, aboriginal people have a historical relationship with the Canadian government, that...a historical relationship which has included a whole lot of terrible injustices, okay? So now, today, we're trying to work with aboriginal, you know, First Nations and other aboriginal groups, to improve their health, but we can't do that without acknowledging and sort of dealing with the injustice that has occurred in the past. But, you know, that's hard to do! Like, we're bureaucrats who are paid to do health, right? But, so, you know, there's a strong component of social justice in the aboriginal health file. You know? Which, right now we have some very good people who are able to work within that frame and to be, to accommodate and acknowledge the part that that plays. You know, but that's really difficult. I mean, another area is, that's close to me, is like the new immigrant situation. And like, what kind of, there are a lot of social justice issues involved in health of new immigrants and how new immigrants assimilate and become healthy, productive members of society. But, you know, it's not really popular to talk about that. I mean, it's...like, generally apart from the aboriginal file, I don't hear people talking about social justice at all.

I: Is that because the social injustice is so...

P: So profound. And so public. (P13-CDP-P)

With all of that said, several participants acknowledged that, despite the importance of social justice considerations in public health, the considerations discussed above falling under the rubric of health equity may be 'better than nothing':

If people don't want, you know, like, uh, the collective consciousness...isn't ready for social justice, then let's just take health equity if that's all we can get, right? It's good, good enough, right? At least it's better than nothing, um, and, you know, maybe once everybody is perfectly comfortable with health equity, of which, you know, a fair number of people are not, uh, then, then we can move on. (P10-CDP-P)

Ultimately you have to go there [engage with social justice considerations], but, I think that health equity becomes a transition point for getting into that, so it's really around how do you take it further? So, we can start with talking about health equity and, and kind of unpack it in terms of readily available data, right? So, we can disaggregate data by income quintile and by maternal education and then we can start to get into, well why, why is it that certain groups are, have less income, like what's going on there, you know? (P07-CDP-P)

What is perhaps most interesting regarding the qualitative differences between my interviews with participants in chronic disease prevention and public health emergency preparedness and response is that the reflections included in this theme about the 'deeper' considerations of social justice not captured by health equity, like the '-isms', are almost entirely absent from my interviews with participants involved in public health emergency preparedness and response.

Relating to several of the ideas presented in this theme, these final thoughts from two participants nicely illustrate the self-reflexive nature of many of the interviews I had with participants involved with chronic disease prevention:

Um, you should ask me why I don't pay more attention to things like social justice, because I'm chasing my tail. (Laughter) No...I won't answer that question! (P20-CDP-F)

P: I guess my last thought would just be that, what the interview has reminded me, is that myself, and I'm sure many other people that work around me, we *know* the right things to do. We're trained and we know these things. You know? We know about...where I work here...these people are highly educated, a lot of PhDs, almost everyone has a master's degree. You know, so we *know* about it, but why is it that it's not integrated or infiltrated into our day to day thinking? Like, that to me is I think a big clue. You know, why aren't *we* raising these issues up more? Why do we accept? You know, we kind of work like within what's acceptable here...I guess it's kind of like a group think happens, and people go with the group think, they don't want to assert something that is outside of current group think, but maybe that's not how you get at real things.

I: These tricky issues.

P: These tricky things.

I: Are there consequences for going outside the box and thinking like that, or...?

P: Well, possibly there are, right? Because if you, like, if you advocate too strongly on ideas that are not flavour of the month, then yeah you could be seen as

‘you’re out of step’. So that’s probably why we don’t do it. But on the other hand, you know, there must be opportunities that...so then we just accept that we’re not doing it, and then you don’t even think of doing it, so then...you know what I mean? That’s what I find really interesting, is through this conversation realizing that *I’m* not talking about social justice, you know? And *I* know what it is and how important it is. So, where’s the disconnect there? (P13-CDP-P)

## 5.4 Conclusion

These findings indicate that social justice is not uniformly interpreted or applied among the public health policy-makers I interviewed. They also indicate that the meanings and roles participants attributed to social justice are influenced—shaped and constrained—by the perceived goals and contextual features that belong to the programmatic area of public health in which they practiced. These findings illustrate that participants largely preferred to use the conceptually proximal value of health equity in discussions of social justice, but that the two concepts were not considered synonyms; that is, they evoke unique justice-based considerations. The next chapter presents a refined interpretation and discussion of these findings, and analyzes them in light of the theoretical and empirical background of this study.

## Chapter 6

### Discussion and conclusion

*“Not only have different nations and individuals different notions of justice, but, in the mind of one and the same individual, justice is not some one rule, principle, or maxim, but many, which do not always coincide in their dictates.”*

- John Stuart Mill, 1861

This chapter provides a refined interpretation and discussion of the findings presented in Chapter 5 and examines them in light of this study’s theoretical and empirical background. On the basis of this discussion, future directions for research, policy, and practice are offered throughout, and the chapter concludes with a discussion of this study’s limitations and the provision of explicit answers to this study’s four research questions.

#### **6.1 Asymmetry in the prominence of ‘social justice’ in theory and in practice: An ‘avoidable and unnecessary disparity’**

Despite common pronouncements in the literature that social justice is a core value for the field of public health (Lee, 2012; Public Health Agency of Canada, 2008), or that it is the very foundation of public health (Krieger & Birn, 1998; Powers & Faden, 2006), this sentiment was rarely overtly expressed in my interviews with public health policy-makers. In fact, not only did my participants rarely overtly express this sentiment themselves, they also indicated that social justice does not play a significant role in the normal discourse in their work (e.g., “we don’t talk about social justice” (P04-PHEPR-P); “I have never seen the term social justice come up in any of the sort of inquiries or conversations” (P16-CDP-M)), or, at best, that it “hasn’t gotten beyond just using [that term] and to what [does that term] actually mean” (P01-PHEPR-M). While this

does not necessarily mean that my study's participants had no views about social justice, that they did not ultimately think that social justice was important to public health, or that justice-based considerations do not in one way or another operate in their work in a manner that is simply not recognized as such (points that I will consider in other sections of this chapter), it is indicative of a disconnect—a 'disparity', if one were interested in engaging in word play at the risk of being less precise—between the ubiquity and stature of the term in the public health literature (especially the theoretical literature) and its perceived role in the discourse of participants' practice in public health.

Now, I did not expect there to be a great deal of symmetry in relation to the depth, breadth, and maturity of public health policy-makers' perspectives on social justice compared to that which is described in the theoretical literature. Asymmetry in these respects, which is indeed conspicuous, was anticipated (and should be expected, I would argue) given the contrasting interests, ambitions, intentions, and roles of public health policy-makers and theoreticians (Swift, 1999). The more surprising asymmetry in my view regards this discordance in the presence and significance bestowed to the concept in theory and in my interviews. Whereas the literature abounds with pronouncements that "[s]ocial justice values are deeply rooted in public health practice" (Edwards & Davison, 2008, p. 130), it is remarkable to me to hear in my interviews that "I don't think we've had a conversation about social justice since I have been here" (P04-PHEPR-P). This, I believe, is an important finding about participants' perspectives regarding the *explicit role* that the value of social justice plays, and speaks to the way in which social justice is 'used' at 'ground level' (Ives & Draper, 2009). Given my findings, one might characterize the way social justice is 'used at ground level' by saying, 'it's not'—at least, my findings suggest the *term* is not commonly used.

My findings point to some possible reasons for this discordance. For instance, if one believes that social justice does not have a single or straightforward definition (e.g., “I think it’s a term that means many different things to different people” (P03-PHEPR-P)), or that there is a lack of clarity surrounding how the value ought to be operationalized (e.g., “of course we support that, but what does it actually look like in practice?” (P19-CDP-F)), I would argue that one should *expect* the term (and concept) not to be commonly present in participants’ practice. As one of my study’s participants expressed, “that’s the crux of the matter, isn’t it? Because, anybody who, if you ask everybody who works in public health what their commitment to social justice and health equity or whatever is, they would probably, uh, you’d probably get, like, a hundred or more different definitions of that, right?” (P10-CDP-P). With the perception that the concept has these qualities, it is difficult to imagine how it *could* play a significant, explicit role in practice (what role would it play other than a rhetorical one?). As another participant argued, “until you come together and...say, okay, this is what we are talking about...I think sometimes that’s the problem” (P16-CDP-M).

So, an important question to pose to my data regards how one might ‘come together and say this is what we are talking about’ with respect to the meaning of social justice in public health. There is no straightforward answer to this question in my data, but my study’s findings provide some important insights. For instance, even if a definition of social justice were to be established for practice, my findings suggest that this may still fall short of what is required for the term to be practicable and applicable for policy-makers. As participants expressed, “these are normative motherhood statements and I don’t know what they mean in [public health emergency] response.” (P08-PHEPR-M); “we can say, like, from a motherhood statement, yeah this is important and it should guide people’s work. What does that mean in terms of the competencies that people, that practitioners should have, policy-makers should have, related to

social justice? That's not clear.” (P19-CDP-F). In other words, the meaning and role of social justice must be articulated beyond what might be perceived as a feel-good platitude or ‘motherhood statement’. Supplying a definition may constitute a starting point for the interpretation and understanding of the value—it may transform the value from a mere ‘motherhood statement’ to one that has substance and carries particular normative attributes—but it may still fail to convey what it means for practice; that is, how it ought to be *operationalized*. Without explicating what a commitment to social justice means for policy and practice, there may still be little or no role for it in policy and practice discussions. These findings therefore not only point to the importance of ‘coming together and say[ing] this is what we’re talking about’, they also suggest that the meaning and scope of social justice must be articulated in such a way that conveys ‘what it actually looks like in practice’. I return to this point of ‘what it actually looks like in practice’ in section 6.3, below, where I discuss the unique themes that emerged between public health policy-makers involved in different programmatic areas of public health.

The idea that social justice must be articulated in such a way that conveys what it ought to look like in practice may not appear to be a terribly novel point in its own right. Indeed, I have made this point throughout this thesis. This finding does a couple of important things, though. First, it provides much-needed support for my argument from those who are actually faced with interpreting this value in practice (Smith, 2015). It is indicative that public health policy-makers do not consider the term to convey practical guidance for their work, and that they desire that this gap be filled (e.g., “the piece that we’re missing is to be looking at it through a social justice lens, and what, you know, what, what does that mean?” (P16-CDP-M)). In other words, this can no longer be considered a merely hypothetical issue. Edwards and Davison’s (2008) conclusion from their study, that “social justice principles should be integrated into all of

the existing domains for [Public Health Agency of Canada's] core competencies" (p. 130) in order to operationalize the value, is therefore reinforced here. Second, it suggests that the lack of clarity surrounding the concept's meaning and the manner in which it should be operationalized might actually be partly responsible for its absence in discussions among public health policy-makers (e.g., "I think talking about social justice becomes...people glaze over for some reason. Maybe it's because everyone has a different idea of what it means." (P13-CDP-P)). Thus, my findings indicate that declaring social justice to be a 'core value' and communicating this in mission and values statements ought to be seen as insufficient if it is to be expected that the value (and its normative considerations, whatever they may be) permeate the discourse of policy-makers' practice.

Indeed, a lack of clarity surrounding what the concept ought to look like in practice might actually lead to a reluctance to engage with the concept altogether. Interestingly, there was an initial reluctance displayed by my participants regarding their willingness to participate in this study, which is reminiscent of my observation in Chapter 1 regarding the reluctance displayed in the public health literature to wade into the murky area in which social justice is theorized and discussed. On several occasions participants told me at the point of recruitment that they were not the 'right' person to speak with about social justice (but did not indicate that such a person exists), that they 'don't work with concept of social justice', or that they have no 'expertise' on the subject matter of social justice. While I cannot claim to know participants' reasons for initially responding in this way, one thought occurs to me given the few instances when participants reflected on their role in having these sorts of conversations during the course of my interviews. In particular, some participants appeared to be slightly embarrassed that they weren't more engaged on this subject: "you should ask me why I don't pay more attention to things like social justice...No...I won't answer that question!" (P20-CDP-F); "that's what I find really

interesting, is through this conversation realizing that *I'm* not talking about social justice, you know? And *I* know what it is and how important it is. So where's the disconnect there?" (P13-CDP-P). These moments of reflexivity among my participants perhaps indicate that at least some felt that they should be paying more attention to social justice, and that, when asked to participate in a study on this topic, worried that this shortcoming would become apparent. I can only speculate that this attitude might also be partly responsible for why, at least from participants' perspectives, social justice does not play much of a role in the normal discourse in their work. Indeed, who would expect policy-makers to be willing to raise or engage with the concept with their colleagues or in their work when this will likely reveal that the meaning of this putatively 'core value' is unclear to them?<sup>1</sup>

The consequence of this discordance (and the corresponding impetus to 'remediate' it) is that it is challenging to establish a dialogue between 'theory' and 'practice' or glean practical insights about the pursuit of social justice when the nature and scope of the value is perceived to be unclear and when it is not routinely used in practice. If, at the moment, social justice "doesn't seem to be permeating the conversation" (P16-CDP-M) among public health policy-makers, then there is limited footing upon which to proceed in overtly discussing or examining how the value is interpreted, negotiated, and used.<sup>2</sup> Certainly, one can proceed with an examination of the *role* that the term 'social justice' plays under these circumstances, as well as an examination of

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<sup>1</sup> For others, it appeared that this was the first time they considered or were being asked to consider what they thought social justice meant, and what they took the concept to mean for their practice (e.g., "Um, man you're tough. You're a tough nut to crack. Holy crap. What does that mean in my personal practice..." (P20-CDP-F); "I was kind of surprised by it, I have to tell you. So, I had to kind of go and look it up." (P18-CDP-M); "Max, actually (laughter) that's a mind boggling one (laughter)..." (P05-PHEPR-F). Of course, one should also expect policy-makers to be less than willing to engage with a concept that is perceived to be foreign to the context of their practice.

<sup>2</sup> It also suggests that there is little footing upon which concerns or beliefs about social justice can be discussed (at least in a consistent manner) among public health policy-makers in practice.

individuals' more general perspectives on the subject. However, an examination of public health policy-makers' perspectives on the ways in which the value and its considerations manifest (if at all) in practice proves more difficult. Success in this domain is, in part, predicated on those involved in public health policy and practice possessing the ability to reflect upon and communicate the practical factors and considerations that attach to the pursuit of social justice in their work—factors that they have unique experiences of, and insights into, given the role that they occupy. If the level and quality of discourse around this 'core value' were enhanced, then public health policy-makers would be better equipped to reflect upon and communicate the ways in which social justice considerations operate (and ought to operate) in their practice. In other words, it could establish a frame of reference that would facilitate the examination, interpretation, and use of this value in future research, policy, and practice. Thus, irrespective of what might be important for theory to do in order to bridge this gap (e.g., enhance the level of theoretical clarity of the value), the level and quality of the discourse in practice in relation to social justice ought to be enhanced if these aims are to be successfully pursued or achieved. It therefore behooves us to explore the obstacles that may be preventing explicit consideration of social justice from occurring as well as the opportunities we might exploit to facilitate this consideration. I will discuss one such obstacle in section 6.2, below. However, before turning to that discussion I will first discuss a potential area of opportunity.

A substantial opportunity to enhance the level and quality of discourse surrounding social justice in public health policy and practice relates to remedying the perception common in my findings that social justice is *incapable* of being defined, or at least of having common attributes. The present concern is that, if one believes "there's no one answer to that...what is social justice" (P10-CDP-P), then one may be apt to dismiss the concept as meaningless and useless. In turn, this might mean that important considerations of social justice that ought to be considered

in, or brought to bear on, public health policy-making are neglected (or, at least, they may remain entirely tacit). This attitude is at odds with the theoretical literature, which demonstrates that a lack of agreement regarding the *desiderata* of social justice need not preclude fruitful and meaningful discussions of the concept from occurring. It illustrates that a ‘commitment to social justice’ need not remain a ‘motherhood statement’ that precludes meaningful discussion and application in the public health context simply because there are ongoing debates regarding the proper aims of social justice. A starting point ought to therefore be to militate against notions that ‘anything goes’ when it comes to defining social justice, or that ‘my interpretation is as good as yours or anyone else’s’, and that there is therefore no reason to engage in a discussion about social justice. Progress on this front is likely quixotic, however, if the field of public health is content to continue to portray its core values as “difficult to teach and even harder to assess” (Public Health Agency of Canada, 2008, p. 3). Indeed, this attitude will likely tend to perpetuate and reify the notion that social justice cannot be meaningfully defined, discussed, and operationalized. It should therefore be considered unacceptable to suggest that ‘core’ values “form the context within which the [core competencies for public health] are practiced” (Public Health Agency of Canada, 2008, p. 3) but leave it to public health professionals to discern in which ways this ‘context’ constrains or countenances particular public health decisions and activities. At the very least, public health professionals ought to be equipped with the skills necessary to discern if, when, and how the value of social justice is applicable to their practice.

In ‘coming together and saying this is what we are talking about’ with respect to the meaning of social justice, my findings therefore suggest that what is perhaps more practically important at this point than “work[ing] out which account of justice we should prefer” (Wilson, 2009b, p. 190) is working out and translating parameters that delimit the sorts of considerations that should attach to the concept of social justice—what could be considered the ‘nature’ and

‘scope’ of social justice. This represents a significant area where normative theory in this area may be able to enhance the way in which social justice is understood in public health; that is, less so in regards to advancing specific accounts of social justice and more so in regards to specifying the particular nature and scope that social justice considerations ought to take,<sup>3</sup> and how these ought to be distinguished from other sorts of considerations (e.g., those entailed by other values, like health equity). I would characterize this as pursuing *conceptual* clarity, rather than strictly theoretical specification. Conceptual clarity could in turn be translated into practical tools that attune attention towards the relevant considerations and questions that are central to social justice in public health. Whereas ‘health equity impact assessments’ provide the framework for contemplating considerations of health equity in practice (Povall et al., 2014), conceptual clarity with respect to social justice could be pursued with a practical focus on the development of sometime akin to a *social justice* impact assessment: what key considerations and questions must be brought to bear on practical public health decisions and activities *as a matter of social justice*?

In any case, in order to remedy the perception that social justice is incapable of being defined, this endeavor ought to be complemented by education directed at countering the perception that values and ethics are merely ‘subjective’, where “the entire enterprise of having a reasoned discussion about ethics is [perceived as] suspect inasmuch as rational dialogue, persuasion, and agreement about ethics and values are impossible” (Jennings, 2003, p. 9). While it is beyond the scope of this chapter to wade into the meta-ethics of this point, the simple argument I would like to make is that, if the field of public health is content to identify social justice (or any value, for that matter) as a ‘core value’ or ‘moral foundation’, then it simply

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<sup>3</sup> Take Powers and Faden’s argument as an example of how the scope of justice could be described: “...much of what justice comprehends lies beyond an assessment of each person’s distributive shares and includes equally concerns about the nature of the relations among persons”.

seems incoherent to at the same time hold that rational dialogue, persuasion, and agreement about the value is impossible. Indeed, what kind of ‘core’ or ‘foundation’ could such a value supply if viewed in this form? What point would there be in identifying core values at all?

Taken together with establishing greater conceptual clarity with respect to the concept of social justice, education on this point could bridge the disconnect between the prominence and quality of discussions of social justice in the public health literature and the way in which social justice is treated in discourse among public health policy-makers, and ultimately render the concept more meaningful and useful in practice.

In sum, this section has discussed what my findings indicate about the *explicit role* of social justice in public health. A salient question that I have yet to address is whether the sorts of considerations or attributes of social justice found in the theoretical literature might merely be expressed and understood in, or applied under the guise of, different terms (or ideas) in practice (e.g., “I don’t know if I would use that exact word [social justice] *per se*” (P09-PHEPR-M)), or whether those considerations and attributes are absent altogether (e.g., “we collect the data and the piece that we’re missing is to be looking at it through a social justice lens” (P16-CDP-M)). Certainly, the concept and prominence of health equity in my data might help to explain, potentially, where these sorts of justice-based considerations tend to reside in practice. I turn to this point next.

## **6.2 Health equity, social justice, and the discursive space for ‘justice-based’ considerations in public health**

My findings say a number of important things about the relationship between health equity and social justice (e.g., themes 5.1.2 and 5.3.3), a discussion of which I believe will help to establish an understanding of participants’ perspectives on the *meanings* and *implicit role* of social justice.

First, my findings indicate that participants considered the meaning of health equity to be ‘clearer’ than social justice (e.g., “I’d say equity, you know, the answer to your question is that equity is clear to me. Social justice, I think the definitions are fuzzy” (P03-PHEPR-P)). Second, in their experiences, participants perceived discussions of health equity to be more common than discussions of social justice (e.g., “we talk about equity but we don’t, we, we don’t talk about social justice” (P04-PHEPR-P)). Third, participants perceived health equity and social justice to be closely related, but did not view the two concepts as synonymous (e.g., “for some reason equity to me seems almost a little bit more, uh, objective or quantifiable, or more easily described, whereas social justice, to me, is, is a much broader, softer concept, um, but more all-encompassing” (P14-PHEPR-F)). Fourth, participants predominantly perceived health equity to refer to concerns regarding differential access to public health programming and services (and their benefits), whereas social justice was predominantly perceived as referring to concerns regarding the social conditions that determine health, and particularly forms of disadvantage produced by social phenomena like racism, sexism, and colonialism (e.g., “I think when we talk about health equity we’re often talking about, you know, a very shallow thinking about access to resources, access to health care” (P07-CDP-P)). Finally, my findings suggest that participants perceived health equity to be easier to ‘sell’, more ‘comfortable’ and ‘neutral’, and less subject to political contestation, as compared to social justice (e.g., “if we wanted to turn our whole society upside down and hand all the power over, I don’t think that’s going to happen, but that, in that, that’s where social justice starts to go, right? Which is where health equity is much more comfortable because it’s like, it’s like just about health, it’s like, I can keep my power but I want to reduce your diabetes, right?” (P10-CDP-P)). Taken together, I interpret these five findings as saying something significant about the tenor and scope of the discursive space wherein justice-

based considerations are raised in, and presumably brought to bear on, public health policy and practice. I will further develop this argument in what follows.

Given the theoretical background to this study, one can safely claim that both health equity and social justice are situated within the theoretical space of justice (Braveman et al., 2011; Smith, 2015). I consider this point to be trivially true (and especially evident for the concept of social justice), but important nonetheless insofar as this means both concepts invoke what I will call ‘justice-based considerations’. By ‘justice-based considerations’ I simply mean any of the sorts of considerations that were discussed in Chapter 2. Now, for some, it may be that health equity and social justice are thought to mean the same thing. That is, they might be thought to refer to the *same* justice-based considerations (e.g., ‘everyone ought to have equal access to public health services’). In that case, it wouldn’t necessarily matter which term is used, as both refer to the same justice-based considerations. The relationship between the two terms would also be less interesting from an ethical perspective (or so I would argue).

My findings are particularly significant because they indicate that participants largely *did not* perceive these terms to be synonyms. Indeed, particular (though not necessarily uniform) justice-based considerations and characteristics were attributed to each concept. Whereas participants described health equity as ‘proximal’, ‘objective’, ‘neutral’, ‘comfortable’, and ‘quantifiable’, social justice was described as ‘political’, ‘structural’, ‘soft’, ‘subjective’, ‘qualitative’, ‘deeply embedded’, ‘broader’, and ‘all-encompassing’. Participants involved in chronic disease prevention in particular described social justice as focusing on or attending to “the very deep issues of...racism, colonialism...and those structural determinants” (P10-CDP-P), and on *why* differences in health outcomes or the social determinants of health exist. Social justice was also described as possessing a salient evaluative (i.e., normative) component (e.g., “talking about social justice...requires that personal confrontation and unpacking about what are

my biases, what am I not comfortable with, how do I feel about certain things” (P07-CDP-P)). Health equity, on the other hand, was described as having a ‘neutral’ and ‘objective’ quality, and as focusing on or attending to the ‘proximal’—access to public health resources and services and the distribution of ‘materialistic determinants’ like income. As one participant expressed, addressing programmatic or service gaps is an aim of health equity, but pursuing these aims will not make a difference to social justice “because the structural things you haven’t changed at all” (P10-CDP-P).

Given its apparent focus on access to services and distributive considerations, I would characterize the way participants talked about health equity as operating rather squarely within the distributive paradigm, and specifically within the theoretical space of ‘equality of access to resources and services’ conceptions of justice. By contrast, given the significance of social relations to the way participants talked about social justice, I would characterize this as operating more within the relational paradigm. While these characterizations should not necessarily be interpreted as being stark and absolute, the point I would like to make is that my findings suggest participants’ conceptualizations of these concepts tended to gravitate towards distinct dimensions of justice-based considerations and concerns. These dimensions of considerations more or less map onto the two dimensions that Kass (2001) considers to be within the scope of social justice: the ‘fair’ distribution of benefits and burdens from public health activities and addressing the social conditions that determine or impact health. My findings suggest that participants’ perspectives on health equity tended to relate to the fair distribution of benefits and burdens from public health activities, whereas their perspectives on social justice tended to relate to concerns of addressing the social conditions (which include social relations) that determine or impact health.

Interestingly, the justice-based considerations that participants perceived to be entailed by health equity and social justice align roughly with different ‘levels’ of determinants of health identified within the Commission on Social Determinants of Health’s (CSDH) (2008) ‘social determinants of health conceptual framework’. Distal determinants identified within this framework include ‘structural’ determinants, like the socioeconomic and political context, macroeconomic, social, and health policy, and cultural and societal norms and values, whereas more proximal determinants include ‘social’ and ‘material’ determinants, like level of education, occupation, income, material circumstances, and interaction with the health care system. Where social justice raised justice-based considerations among participants that predominantly regard this ‘structural’ level of determinants (e.g., “it’s a materialistic interpretation of inequity rather than an understanding of sort of deeply embedded, um, sort of cultural or structural or other kinds of norms.” (P07-CDP-P); “a social justice impact assessment would actually get to the very deep issues of social justice, like, um, racism, colonialism...I guess those structural determinants as opposed to social determinants.” (P10-CDP-P)), health equity raised justice-based considerations that predominantly regard material circumstances and interaction with the health care system (or public health ‘system’) (e.g., “we look at all the areas that will encourage access to our methadone programs and our needle exchange programs, and all of that, but yet, we also need to really look at the, the policies, federally and even provincially that perpetuate social injustice.” (P17-CDP-M)).

The upshot of all of this is that, in contrast to the hypothetical case where the two concepts are treated as synonyms (where either term could be used to refer to the same justice-based considerations), this finding suggests the concepts are ‘used’ to point to *different* considerations, which emphasizes the importance of examining the extent to which each concept is ‘used’ and the role each concept plays in public health policy and practice. As previously

mentioned, my findings indicate that participants were more comfortable speaking about health equity, that they perceived health equity as having a ‘clearer’ meaning, and that discussions of health equity were perceived to be more common than were discussions of social justice. Moreover, my data on the whole illustrate that engaging participants on justice-based considerations in public health by conducting interviews specifically about ‘social justice’ elicited discussions of ‘health equity’. Indeed, unless participants were asked explicitly to tease apart the meanings they attributed to the two concepts, participants nearly systematically shifted conversations towards health equity. In fact, participants even acknowledged doing so, citing their greater comfort and familiarity with health equity (e.g., “you can hear what I’m saying about social justice and having some conceptual lack of clarity about that, so I could speak more to health equity but perhaps not social justice” (P19-CDP-F)). For these reasons I interpret my findings as indicating that *health equity dominates the discursive space wherein justice-based considerations are expressed among public health policy-makers*. As a result, my findings suggest that the justice-based considerations that are discussed and ostensibly brought to bear on public health activities are primarily those imbued by the concept of health equity.

This interpretation need not be assessed solely on the basis of the analytic moves I’ve made in the foregoing paragraphs. In fact, this idea was alluded to by participants themselves. For instance, one participant indicated that, “social justice...I would say we’re not, we’re not there yet as a health unit...I mean, we are still looking at the equity piece” (P18-CDP-M). I interpret this to be indicating that social justice and equity are distinct (otherwise, looking at the ‘equity piece’ would entail looking at the ‘social justice piece’), and that this particular health unit was perceived as concerning itself with the sorts of considerations entailed by equity, and not social justice. Hence, for this health unit, justice-based considerations were perceived as being taken up by ‘looking at the equity piece’ more than looking at the ‘social justice piece’.

As another participant stated: “What’s the social justice impact of housing policy, of daycare policy? Let me tell you that will, that will take the conversation in a, in a different direction, I believe, in a deeper, richer direction, than just, uh, and I don’t mean just, but, than simply talking about health equity or inequity” (P17-CDP-M). I interpret this as suggesting that, again, health equity and social justice are perceived to be distinct, and that examining the social justice impact of a given public health policy will take the conversation in a different direction *than where the conversation is usually directed*, which is towards the consideration of health equity.

The idea that health equity dominates this discursive space is also supported by examining the perspectives of participants regarding the relative ‘ease’ at which health equity and its particular considerations can be ‘used’ in comparison to social justice. Participants perceived health equity as “easier to sell” (P18-CDP-M), “simplify[ing] our lives” (P10-CDP-P), and “safe” (P13-CDP-P), whereas social justice was described as being “really difficult” (P13-CDP-P) and subject to “political sensitivities” (P18-CDP-M), eliciting “very strong reaction[s]” (P10-CDP-P) and requiring a personal confrontation of biases and privilege “that people don’t have the time or the inclination to do” (P07-CDP-P). This may in fact be best represented by the views of one of my study’s participants, who on the one hand stated that “the term equity has been beaten to death for some reason”, but when discussing institutional racism and its impact on poor health outcomes, said: “that’s social justice, right? But not in here.” (P13-CDP-P).

In other words, my findings indicate not only that participants perceived discussions of health equity to be more common than social justice, but also that particular obstacles were perceived to exist that prevent or preclude discussions of social justice (and the considerations imbued by the concept) from occurring. The prominence of health equity in the space wherein justice-based considerations are discussed may stem from the fact that the concept operates in such a way that allows one to raise and apply putatively ‘neutral’, ‘objective’, and ‘proximal’

justice-based considerations without wading into the divisive, normative, and uncomfortable territory of social justice. It facilitates the consideration of justice in relation to public health activities without asking ‘deeper’ questions about *why* health inequities exist, without confronting ‘deeply embedded structural or cultural norms’, and without ‘handing over power’.

While there is nothing inherently problematic with attending to questions of justice that attach to issues of access to resources and services (i.e., to the ‘material’ or ‘proximal’ determinants of health), it ought to be concerning for at least three reasons. First, it is concerning if this altogether supplants attention towards other considerations of justice, and especially those that concern upstream injustices that ultimately sustain or exacerbate issues of access to public health resources and services (i.e., to ‘structural’ determinants of health). Indeed, attending to issues of access alone fails to address other key aims widely considered to be important to justice, including the correction of “patterns of systemic injustice among different groups, seeking to improve rather than worsen systematic disadvantages in society” (Kenny et al., 2010, p. 10). What we are left with, then, is a concept of equity that is detached from the structural and societal considerations of social justice—considerations that are of central importance to nearly every account of social justice developed in the public health context (Daniels, 2007; Powers & Faden, 2006; Venkatapuram, 2011).

Remediating ‘inequities’ in terms of access to public health services and resources is no doubt an important aim of justice. This aim recognizes that an injustice obtains when individuals or populations are deprived of particular benefits given their unequal access to those benefits. This is reflected in Powers and Faden’s (2006) Basic Well-being Aim of justice, for instance, which seeks to combat *deprivation* in well-being. Injustice is located in the adverse consequences for well-being that may obtain from inadequate access to important public health services and resources, and so addressing concerns of access works to remediate deprivation and,

thus, advances the Basic Well-being Aim of justice. However, this may do little, if anything, to combat the ‘enemy’ of the other aim of Powers and Faden’s Twin Aim Theory of justice, which is *disadvantage*. The second aim of justice for Powers and Faden is their Structural Fairness Aim, which locates injustice in the structural unfairness of social arrangements that distribute advantages and disadvantages. This aim requires that forms of disadvantage (e.g., discrimination on the basis of race or gender; prejudice; stigma; subordination), and not simply deprivation, be considered in the assessment of justice. Operationalizing justice-based considerations solely through the remediation of ‘inequitable’ access to services and resources will fail to adequately address (or take into account) unfair social arrangements that may prevent individuals or populations from realistically improving their prospects for well-being and exiting a state of affairs where they are constantly at risk of decline. Thus, the ways in which disadvantage create and sustain significant social impediments to the realization of well-being ought to be considered alongside the assessment of how differential access to services and resources might deprive individuals or populations from a sufficient level of well-being. It may therefore be particularly important to explore how Powers and Faden’s Structural Fairness Aim of justice, as well as other thinking around disadvantage (e.g., Wolff & de-Shalit (2007)), can be translated and incorporated into public health policy and practice in order to affirm or emphasize disadvantage as a distinct normative concern of social justice.

Second, by severing a connection between the sorts of justice-based considerations imbued by health equity and those imbued by social justice, it may be that the normative assumptions and commitments of health equity can be more easily taken for granted.<sup>4</sup> If

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<sup>4</sup> Indeed, it is difficult to imagine how this connection could coherently exist given participants’ characterizations of the two concepts. If health equity is ‘neutral’ and ‘objective’, how could it be that its meaning is somehow derived from a concept that is perceived to be ‘political’ and ‘subjective’?

addressing unequal (or ‘inequitable’) access to public health services is perceived as ‘neutral’ or ‘objective’—that is, if it is not in some way linked to the normative concern of injustice—then one may end up addressing those ‘inequities’ that are easiest to remediate, those that may be far down on the list of inequities that *ought* to be remediated, or those that may not actually be important to remediate as a matter of justice. In this form health equity loses its critical capacity and establishes a path of least resistance to assessing and incorporating justice-based concerns and considerations in public health. If one were interested in being provocative, one might argue that health equity, at least in this form, is bad for the public’s health.

Third, the attenuated scope of justice-based considerations that participants perceived to be attached to ‘health equity’ raises concerns given the increasing stature and role of the aim of ‘reducing health inequities’ in public health. Indeed, in recent years the reduction of health inequities has been placed at the top of public health agendas at every level of government across Canada (National Collaborating Centre for Determinants of Health, 2011; Public Health Agency of Canada, 2014). Despite this, we know that health inequities persist and are growing among certain populations in Canada (Public Health Agency of Canada, 2015). Two of the central barriers to advancing health equity goals in Canada have been identified as (1) mobilizing action across *non-health* sectors and (2) collaborating *intersectorally* given competing pressures and sector-specific terminologies and approaches (Public Health Agency of Canada, 2011). In other words, no matter the enthusiasm *within* public health to reduce health inequities, substantial and sustainable progress on health equity appears to be predicated on the willingness and capacity of non-health sectors to support and invest in this public health goal.

Unsurprisingly, then, significant attention has been devoted to studying and developing intersectoral strategies to reduce health inequities (Bauer, 2014; Hankivsky et al., 2014; Storm, den Hertog, van Oers, & Schuit, 2016; World Health Organization, 2008). Yet, for these

strategies and the research conducted to inform them to be successful, they ought to account for how different goods and aims are valued in different sectors and how this might constrain the pursuit of health equity in non-health sectors. Indeed, the values and aims undergirding public health's pursuit of health equity—however it manifests—may ultimately be at odds with social policies and practices in other government sectors, which may consider the reduction of health inequities to be peripheral to, if not incompatible with, their own context-specific values and objectives. For example, in the area of education (a central social determinant of health), health and health equity may understandably be overlooked or deprioritized if they come at the cost of particular educational objectives or if they conflict with the education system's pursuit of 'equitable' education processes and outcomes. In the absence of a conceptual framework to understand and account for different values that may exist in different government sectors, intersectoral strategies to reduce health inequities may be inhibited or altogether thwarted. It is therefore critical that government-wide, intersectoral strategies to reduce health inequities engage with these broader considerations of social justice.

Social justice requires one to think about the different weights that ought to be given to different social goods and objectives, including the remediation of health inequalities. However, it does not (necessarily) prioritize the remediation of health inequalities over other social objectives. As such, equity in health may be one of many aims that social justice requires. Which weights ought to be given to different social goods and objectives is a question that can be significantly informed by the philosophical literature (e.g., Weinstock (2010, 2015a)), and future empirical research in this area. Engagement with social justice as a core value of public health necessitates much more expansive and challenging thinking than what seems to be currently operating with respect to health equity regarding the proper justice-based aims that ought to be achieved by public health and the trade-offs that can be justified in the pursuit of

social justice. Thus, given the increasing importance attributed to the intersectoral pursuit of health equity, there is an even greater imperative to conceptually ground health equity within a conception of social justice. While this study sought to explore perspectives on social justice in public health, it seems that there would be utility in future research that aims to explore perspectives on social justice in different government sectors and examine how those perspectives might align in order to develop a coherent intersectoral strategy for the reduction of health inequities. In addition to enhancing the conceptual framework for such an intersectoral strategy, this could also further enhance an understanding of the ways in which health equity might fit into the broader pursuit of social justice.

This general finding and interpretation significantly nuances the current understanding of the relationship between health equity and social justice that exists in the empirical literature. One will recall this literature reports that social justice is commonly perceived to be important, or in some way linked, to health equity (though this conceptual relationship has not been previously explored empirically). For instance, Rizzi (2014) reported that, for the frontline public health practitioners who participated in her study, the “theme of *fairness* was [a] dominant [frontline staff] descriptor of health equity, and [was] often made in reference to the concept of social justice” (p. 47). In addition, Knight (2014) stated that, in her study, “[p]articipants described the role of the field in addressing health inequities as being grounded in the evidence base, as well as in the value of social justice, which they believed were mutually reinforcing. Recognizing that social justice underlies health equity requires strong engagement with the political process” (p. 192). My data echo Knight’s finding insofar as my participants similarly expressed that social justice concerns the political process and underlies health equity (e.g., “I see social justice certainly as the, the political piece of equity, and that’s perhaps just my interpretation, but I look at social justice more in terms of that piece and I look at equity much along the things of, so,

what's equitable in terms of programs and services" (P18-CDP-M)). However, my findings refine this understanding by indicating that the perceived link between social justice and health equity does not necessarily equate to the fact that social justice considerations will be systematically considered or addressed when health equity is invoked. To the contrary, my findings indicate that health equity may actually provide a way in which to discuss justice-based considerations without engaging with the contentious subject matter of social justice, including the 'political piece' (or at the very least may provide a way to do so that takes these social justice considerations for granted).

Thus, on the basis of this background empirical literature alone, one might simply infer that health equity and social justice are somehow mutually reinforcing in practice; that health equity is imbued with considerations of social justice, and so when health equity is invoked it 'brings along' social justice considerations and therefore helps to advance social justice aims (the theoretical literature reinforces this idea—something I will return to shortly). Yet, while my findings indicate that participants perceived a link to exist between these two concepts, they also indicate that participants perceived the two concepts to focus attention—and, importantly, the nature and scope of justice-based considerations—towards different concerns that are not clearly connected. My findings suggest that the concept of health equity occupies a discursive space wherein 'uncomfortable' justice-based considerations of structural '-isms', power imbalances, and systematic disadvantage can be eschewed (or simply taken for granted) in favour of attending to 'proximal' inequities in areas like income distribution or access to public health programming or services. Engaging with divisive, political considerations is avoided by appealing to a concept that is putatively objective, neutral, and quantifiable. The latter becomes 'easier to talk about', 'easier to sell', and 'safe', and for some may altogether obviate their

perceived need (or appetite) to engage with the more challenging social justice considerations (e.g., “let’s just take health equity if that’s all we can get” (P10-CDP-P)).

The findings from Pinto and colleagues’ (2012) study discussed in Chapter 3 provide further insights into thinking about the nature of this relationship, and specifically into considering the potential obstacles that may inhibit social justice considerations from appearing in public health policy-makers’ practice discourse. In their study, which examined the extent to which an ‘equity lens’ has been incorporated within the provincial public health standards in British Columbia and Ontario, Pinto and colleagues found that only a ‘few’ of the twenty-six protocols in the Ontario Public Health Standards (OPHS) explicitly identified ‘reducing inequities’ as a goal. The authors hypothesized that this is reconciled within the OPHS by its framing of the ‘reduction of health inequities’ as a *societal* outcome rather than an outcome meant to be achieved by any single protocol (e.g., ‘public health emergency preparedness protocol’). In confronting my findings with this hypothesis, it could be that the sorts of justice-based considerations that are ‘meant to be achieved’, or perhaps that are perceived as ‘possible to achieve’, by any single protocol, by any specific public health activity, or indeed by any particular programmatic area of public health, are seen as lying rather squarely within the ‘health equity paradigm’, which is capable of addressing issues of access to those services or programs. Broader societal outcomes—those perhaps captured more so by the ‘social justice paradigm’—might therefore be considered more so aligned with the aims that are only possible to pursue or achieve by public health as a whole (and in conjunction with other sectors). Hence, if the ways that individual protocols, like public health emergency preparedness and response, are not conceptually and practically linked to broader social justice aims, then those individual protocols (or programmatic areas) may simply do whatever they can to remediate inequities locally; that is,

through remediating issues of access to whatever services or resources that are entailed in the protocol or programmatic area's routine activities.

Thus, attention ought to be directed towards understanding and articulating the context-specific ways in which different protocols, public health activities, or programmatic areas of public health should be configured—both internally and in conjunction with other protocols, activities, or programmatic areas—to achieve the broader aim of ‘reducing inequities’ *beyond* merely ensuring that unequal barriers to accessing their respective services and resources are removed. This is an area in which normative theory can make an important contribution. That is, normative theory ought to examine the specific ways that different activities, like chronic disease prevention and public health emergency preparedness and response, each ought to contribute to the broader aim that public health has as an institution to promote social justice. Surely, different programmatic areas of public health are capable of contributing something unique to this aim, and some are likely better situated than others in realizing elements entailed by this aim. Yet, it is unclear what it is exactly that ought to be emphasized for each area beyond ensuring that their services and resources are ‘equitably’ distributed. While a theory such as Powers and Faden’s (2006) may be instructive or useful in framing how the broader aims of public health as an institution ought to be designed (indeed, their theory is specifically “addressed to questions about the design of the basic social structure”, where “the practical guidance our theory provides...is frequently one step removed from the kinds of midlevel and micro-level decisions that public health officials...make on a daily basis” (p. 143)), its implications for how the context-specific aims and activities in particular programmatic areas of public health require further thought and specification.

This finding regarding the relationship between health equity and social justice is also important given the theoretical background to this study. As I argued in Chapter 2 (section 2.3.2

in particular), the concept of health equity should be considered at least partly dependent on a more robust conception of justice to do some (if not all) of its normative work (i.e., to specify what constitutes ‘unjust’ differences in health), and that specification of such a conception of justice is therefore required in order to furnish the normative component of health equity’s definition (Smith, 2015). One might be tempted to look to my findings about participants’ perspectives on social justice, then, to say something about this normative component of health equity’s definition. Yet, to interpret or ‘use’ my findings to say something about how health equity ought to be understood given my participants’ perspectives on social justice would discount this interesting finding about the relationship between health equity and social justice. Indeed, that the most common account of health equity in public health is entangled with notions of justice does not seem to have penetrated many of my study’s participants. Instead, it seems that participants perceived health equity to be rather disconnected from the normative questions of justice that I argued must be specified in order to furnish health equity’s meaning. Indeed, the assumptions and considerations of justice operating within participants’ perspectives of health equity were perceived as additional considerations that “people don’t have the time or the inclination” (P07-CDP-P) to address. Thus, I am not entirely convinced by some of my participants’ views that this current understanding and role of health equity ought to be considered “better than nothing” (P10-CDP-P), or that it acts as a suitable ‘starting point’ or ‘transition point’ where progress can slowly be made towards tackling the ‘broader’, ‘deeply embedded’, and ‘all-encompassing’ concerns of social justice.

Interestingly, there was one exception to this point within my data, and that regards the state of aboriginal health (e.g., “apart from the aboriginal file, I don’t hear people talking about social justice at all” (P13-CDP-P)). Participants’ perspectives indicate that the term ‘social justice’ may have in fact been ‘normalized’ in the aboriginal health context; it is so visible, so

‘public’, and so profound that it is perhaps impossible to ignore. This can be contrasted with other ‘injustices’ that participants discussed. For instance, the same participant who discussed the ‘profound’ and ‘public’ injustice of the state of aboriginal health also asked rhetorically: “Talk about racism in here? Are you kidding?” (P13-CDP-P). While generally there is a “very strong reaction to the word social justice” (P10-CDP-P), “political sensitivities around the degree of advocacy one can proceed with” (P18-CDP-M), and a requirement of social justice to conduct a “personal confrontation and unpacking about what are my biases, what am I not comfortable with, how do I feel about certain things?” (P07-CDP-P), these reactions, sensitivities, and reluctance to confront and unpack personal biases are perhaps assuaged in the aboriginal health context, as if disagreement about the prevalence of social injustice in this context is no longer deniable or possible to ignore.

This points to a key area where social justice theory might be able to enhance or refine the way in which social justice is understood and incorporated into practice. The visibility and profoundness of the social injustice that is perceived in the case of aboriginal health and the impact of this perception on the willingness (or at least ability) to speak about it points to the need to cultivate skills among public health policy-makers to discern what makes something a social injustice, which is especially important in less visible, and perhaps less profound, cases. Theory, with adequate knowledge translation efforts, could transform a ‘you know it when you see it’ attitude towards the identification of social injustice into a critical outlook of ‘you see it when you know it’. However, to ‘know it’, one must have an understanding of the normative features that distinguish some state of affairs as unjust. Making social justice ‘teachable’ and ‘assessable’ therefore should not simply be seen as finding a suitable manner in which to teach the theoretical landscape of social justice and assess the extent to which this landscape is reflected in public health policy and practice. Rather, my findings lead me to believe that

making social justice teachable and assessable involves cultivating the skill of moral discernment, which would enable public health professionals to identify issues and concerns of social justice (Rhodes, 2012).

The preceding discussion concerning the relationship between social justice and health equity must be qualified given how this relationship uniquely manifested in discussions with participants in each programmatic area from which my study's participants were recruited (a matter that I will more robustly consider in the next section). While participants involved in chronic disease prevention spoke about justice-based considerations in terms of health equity and social justice, and did so according to my interpretation above (this was a theme constructed from these interviews), participants involved in public health emergency preparedness and response did not make as stark a distinction between the two concepts, and, with some nuance, tended to speak almost entirely about the justice-based considerations that fall under the rubric of 'health equity', as described above (i.e., in relation to considerations of access to services and resources). In other words, while participants involved in both programmatic areas spoke about equity and perceived that particular concept to predominantly focus on or attend to proximal issues of access to public health resources and services, discussions of 'structural determinants', 'deeply embedded' social and cultural norms, and social phenomena like racism, sexism, and colonialism were absent in interviews with those involved in public health emergency preparedness and response. In turn, there is little to no evidence within the interviews in this context that participants had a sense of how public health functions at a structural level to create or remediate social injustice.

This is particularly evident in how the 'position' of the population was taking into consideration in participants' discussions of social justice. As one participant involved in chronic disease prevention expressed, "there's so much going on, so is it unfair and unjust their

access to the program? What's unfair and unjust is that they are in that position in the first place" (P07-CDP-P). This can be contrasted with the perspective of a participant involved in public health emergency preparedness and response, who stated: "the fact that, I mean it's already unfair in the scheme that someone has, um, someone is in a position where they are going to be disadvantaged, right? That's already unfair. So, um, yeah. Life ain't fair they tell me" (P14-PHEPR-F). Whereas the conditions in which populations find themselves were seen as the 'normal' or 'givens' to which public health emergency preparedness and response endeavors to restore rather than remediate (but not exacerbate), these conditions were perceived as problematic and important to remediate for those in chronic disease prevention. Indeed, one of the central aims of chronic disease prevention was described as identifying 'social discrepancies' and exploring how those discrepancies can be prevented and corrected. This latter view aligns with Powers and Faden's (2006) argument that achieving justice is an inherently remedial task. This represents an interesting 'starting point' that differed in each participant group's perspectives on social justice.

The fact that considerations of equity largely constituted the sole justice-based considerations discussed among participants involved in public health emergency preparedness and response means that these justice-based considerations were almost entirely situated within the distributive paradigm (as the sorts of considerations perceived to be imbued by health equity largely fall within this paradigm). Whether 'saving the most lives' was considered to align with social justice or whether social justice was seen as requiring public health emergency preparedness and response to be 'equitably distributed' in terms of the resources required for vulnerable populations to be 'resilient' (e.g., "I think it would focus on the amount of, uh, the treatment of our most vulnerable people. I think there is a theme in there that the, that the level of support meets our concepts of, uh, you know, justice and dignity." (P08-PHEPR-M)),

participants involved in public health emergency preparedness and response rarely, if ever, raised the sorts of considerations falling under the relational paradigm.

This means that the relational quality of social justice was nearly entirely absent among the perspectives of participants involved in public health emergency preparedness and response. Where the social determinants of health were discussed, their significance was eclipsed by the importance bestowed to the primary aims and activities of public health emergency preparedness and response. This is reflected in the point expressed by one participant, who said: “I think there are significant issues around equity related to the outbreaks of measles that public health could be working on, so it’s not to say I am not, we shouldn’t deal with that, and, and there are many vulnerable populations that don’t have appropriate levels of immunization and we are working on that, but the, the bigger picture social justice that we are going to solve world poverty, uh, I, I think if public health people want to do that than they should go work in ministries of finance” (P03-PHEPR-P). This quote illustrates how justice-based considerations were considered relevant and important when articulated in terms of ‘equity’, which in this case attached to access to immunizations and other public health services, but that the justice-based considerations that better align with ‘social justice’ were considered beyond the scope of public health emergency preparedness and response. A more explicit consideration of the ways in social justice was discussed in each programmatic area of public health will occur in the next section.

### **6.3 The ‘mean’ and the ‘margins’: ‘Local’ justice in public health?**

My findings suggest that the perspectives of participants involved in distinct programmatic areas of public health—chronic disease prevention and public health emergency preparedness and response—differed in several respects, and that these differences appear to be important for how participants talked about the meaning and role of social justice. I will discuss some of the ways

in which social justice was discussed in each context and pick up on several key differences given their significance to my research questions and the theoretical and empirical background to this study.

The perspectives of participants involved in different programmatic areas of public health differed saliently in regards to the ways in which they talked about the ‘target’ or intended recipients of the public health activities in their respective programmatic areas. For instance, those involved in public health emergency preparedness and response tended to talk about targeting their activities towards the ‘mean’, the ‘welfare of the group’, or the ‘greater good’, whereas those involved in chronic disease prevention tended to talk about taking the myriad differences between populations into account when implementing their public health activities, and subsequently targeting the ‘right’ population (i.e., those with the greatest need). Consider the following extracts, which highlight this difference:

*Public health emergency preparedness and response*

“We know that population *x* isn’t going to be served by our program, um, so, um, but we have to implement that program for the greater good...Often emergency planning and, uh, emergency management is, uh, directed at the mean, right?” (P14-PHEPR-F)

“It’s always possible that some individuals will fall through the cracks. But the goal is, is, um, is basically the welfare of the group.” (P05-PHEPR-F)

“If you just take hypertension, high blood pressure in the population, there are people who think that the goal should be, focus on the people with the worst high blood pressure, find out who they are, identify them, treat them, and you’ll bring the whole curve down. And other people who say we need to take a public health approach, we need to focus on everybody in the population to bring that whole curve downwards for all those people.” (P01-PHEPR-M)

*Chronic disease prevention*

“I feel my kind of compassion and commitment for social justice, I think to myself, Max, if we’re not working on the margins I have always felt this in public health and yet I’ve over my career have gone through periods where I felt a real

kind of...the way I was being asked to work and, and really where my value base takes me in public health. Um, that I think if we're not working on the margins that is social injustice in my mind." (P17-CDP-M)

"A social justice perspective has to take into consideration multiple population groups." (P19-CDP-F)

"Public health interventions, there's no, there's no one size fits all." (P12-CDP-F)

A rather simplistic but pithy characterization of the difference present between these perspectives is that public health emergency preparedness and response was described largely in relation to the 'mean', whereas chronic disease prevention was described largely in relation to the 'margins'. Another way to characterize this difference is that those involved in chronic disease prevention were concerned with distributive considerations, whereas those involved in public health emergency preparedness and response were concerned with maximizing positive outcomes with less concern for distributive considerations.

Participants perceived chronic disease prevention as being fundamentally concerned with taking differences between populations into account to advance its goals, and considered this as embodying a concern for justice (e.g., "people aren't talking about it by way of social justice, but I think...our work...is more reflective of the distribution of  $x$ , whatever  $x$  might be...If there are discrepancies and there usually are, whether it's between people or across time by way of trends...then that is something that's our bread and butter." (P20-CDP-F)). In other words, the described goals of chronic disease prevention were interpreted *in terms of equity and social justice*. Whereas, on the other hand, participants predominantly interpreted and described the goals of public health emergency preparedness and response independently from justice-based considerations. The main goals of public health emergency preparedness and response were described as 'restoring the norm', 'saving lives', and producing the 'greatest good'. While one participant explicitly equated this goal with an aim of social justice ("using your resources to

save the most people, simply put. Is that social justice? I would say it is.” (P02-PHEPR-P)), justice-based considerations were largely seen as separate from these goals, and were described as directing attention towards those who, due to public health emergencies, require more resources in order to be resilient (e.g., “in my mind, personally, it means those who don’t have the resources, um, to be able to be as resilient as others.” (P02-PHEPR-P); “I don’t think that they think of equity specifically, that’s what comes across the front of their minds, but buried in the, the immediate reaction I think, um, is the need to look after those vulnerable populations.” (P11-PHEPR-F); “The event causes them to be vulnerable. Our ability to, to identify them, and try to, uh, overcome their barriers to access existing services.” (P08-PHEPR-M)). More than constituting external considerations that extend or act to calibrate the goals of public health emergency preparedness and response, these considerations were perceived as possible constraints on the ‘utilitarian’ aims that were seen as being entailed by the ‘public health approach’ to emergency preparedness and response (e.g., “I think it’s, in principle an important thing to say, but in practice is going to be, there are so many moving points at that time that putting that extra constraint on may, I mean it may or may not be, and it really depends on the situation, a real impediment, perhaps.” (P01-PHEPR-M); “how high a price do you pay for social justice?” (P02-PHEPR-P)). Interestingly, this seems to reflect Powers and Faden’s characterization of the ‘standard way’ in which the ethics of public health is understood. That is, Powers and Faden present their theory of social justice as a position contrary to what they consider to be the ‘standard’ view in public health, which is that the “moral foundation for public health...rests on general obligations in beneficence to promote good health”, which may be further understood as “having utilitarian commitments to bring about as much health as possible”, where “[c]oncerns about justice are commonly understood as ethical considerations external to the moral purpose of public health” (Powers & Faden, 2006, p. 9).

Given the specific theoretical attention paid to hypothesizing about the nature of justice in the context of public health emergency preparedness and response, I will digress from this narrative briefly to discuss the ways in which my findings relate to these particular statements made in this literature, as reviewed in Chapter 2.

My findings from interviews with participants involved in public health emergency preparedness and response illustrate the centrality of notions like the ‘mean’ and the ‘greater good’, and even reveal that ‘utilitarianism’ is part of these participants’ discourse. This appears, at least at first glance, to correlate with claims in the theoretical literature that “public health has strong roots in utilitarianism because of its fundamental focus on collective health” (Nixon & Forman, 2008), or that “[p]ublic health is concerned with the broadly utilitarian aim of maximizing the aggregate health of the population” (Faden & Powers, 2008, p. 152). And, much like I gleaned from the theoretical literature, the discourse of utilitarianism appears to be particularly evident in discussions in this particular context; interviews with those involved in chronic disease prevention did not include any mention of ‘utilitarianism’ or the ‘greater good’.

With that said, my findings do not necessarily provide strong support for the notion that there is a “retreat to the utilitarian ethic” (Veatch, 2005, pp. 240-241) in public health emergency preparedness and response, or that “the force of this utilitarian aspect becomes the primary consideration in proportion to the threat” (Kirkwood, 2010, pp. 1-2) in public health emergency preparedness and response. On my interpretation, this would entail the aims of justice to *shift* in the case of public health emergency preparedness and response; that justice would *require* something akin to utilitarianism in this context, where it does not in other contexts (i.e., in ‘quotidian’ public health). While one participant seemed to suggest that he believed something like this (e.g., “the concept of social justice for a population and an individual, the concept is the same, I mean, it, again, if you, um, if you look at it through, to some extent as we do in public

health, a utilitarian lens, uh, the concept's the same, but the application is much different because of the circumstance...using your resources to save the most people, simply put. Is that social justice? I would say it is.” (P02-PHEPR-P)), the perceived utilitarian goals of public health emergency preparedness and response were generally separated from what participants took to be concerns and considerations of justice. In other words, it was not that participants described justice as requiring something distinct in the case of public health emergency preparedness and response, but rather that public health emergency preparedness and response has self-evident ‘utilitarian’ aims, and that these aims are constrained by social justice considerations, which manifest as a concern for populations that are more vulnerable as a result of public health emergencies. Thus, I do not interpret my findings as suggesting that the meaning of social justice necessarily *changes* in a public health emergency, nor that a *different* conceptualization of social justice necessarily obtains in the public health emergency preparedness and response context. Rather, I interpret my findings as being supportive of the idea that it is the *role* of social justice considerations in public health emergency preparedness and response that is distinct from that which was found from interviews with participants involved in chronic disease prevention. Where justice-based considerations are part and parcel of the aims of chronic disease prevention, they are external to, if not constraints upon, the ‘prior’ aims of public health emergency preparedness and response.

While clearly only speculative, this may be due, in part, to a perceived difference in what Hume (1998 (1751)) characterized as the ‘circumstances of justice’. Hume argued that the concept of justice is not applicable to all situations. For instance, in circumstances where particular goods (e.g., public health resources) are abundant and easily accessible, Hume argued that issues of justice simply would not arise. However, Hume also argued that extreme scarcity makes justice inappropriate, meaning that if a good is so scarce such that people’s survival is in

doubt, then in this circumstance justice may become a luxury (Hume, 1998 (1751); Wolff, 2007). While it is beyond the scope of this thesis to fully explore and defend the merits or plausibility of Hume's argument, it seems that this sort of thinking may have penetrated the perspectives of my participants involved in public health emergency preparedness and response. First, participants appeared to take scarcity as a given in this context (e.g., "it's a matter of time and, and resources and, and having to, uh, having to, uh, invest maximally, um, you know, where you are going to get the, the maximal impact, but knowing, knowing that there are needs that are, are very, um, valid that are going unmet because you don't have the resources to cover them all equally" (P14-PHEPR-F); "at some point there will be not enough of something" (P08-PHEPR-M); "using your resources to save the most people" (P02-PHEPR-P)). Second, it seems that consideration of justice in public health emergency preparedness and response was in some cases perceived as a luxury of sorts in the way Hume meant (e.g., "there's just no time for discussing those diverse opinions because it's just usually a bit of a, you, it's a, it's putting out fires." (P01-PHEPR-M); "in those cases I'd love to be able to tell you, oh yeah, there's a lot of triaging that goes on, but in the initial aftermath of that particular tornado sometimes it's just who's, who's, you know, who's there?" (P06-PHEPR-P); "If focusing on those ideas would be, would, or would be perceived to take away resources from managing the overall issue, whatever it would be, let's say an epidemic, then, then it's just, you know, that's just not going to be on the agenda." (P01-PHEPR-M); "I think it's foolhardy for public health to go off trying to reduce, uh, wage inequities when there's still you know, outbreaks of measles happening in this province." (P03-PHEPR-P)). Thus, my findings do not appear to indicate that thinking about social justice is perceived to be 'pointless' in the public health emergency preparedness and response context (Jennings & Arras, 2008), but rather my findings suggest that thinking about social justice may be perceived to be a

‘luxury’ that cannot always be addressed given the immediate and more basic perceived need to ‘save as many lives as possible’ and ‘restore the norm’ during a public health emergency.

Indeed, these ‘circumstances’ seem to have made it difficult for participants to appreciate the relevance of social justice or equity considerations. The case of bed bugs discussed by one participant is illustrative of this point. As the participant who raised this example expressed: “what’s the health equity issue, right? Like, the people that might be poor, they might be rich, whatever. Like, what do you, what do you want me to do about this health equity thing?” (P10-CDP-P). The same sentiment was raised in relation to the case of an infectious disease outbreak: “It’s just whoever happens to get sick, right?” (P10-CDP-P). These examples illustrate how participants perceived the circumstances of public health emergency preparedness and response to dictate a rather straightforward reaction, where considerations or concerns of justice appear to be extraneous, if not irrelevant.

This represents an area ripe for further normative examination. A central question that these findings raise is whether different contexts of public health practice or different public health challenges involve different ‘circumstances of justice’ that modulate (or ought to modulate) the role that social justice considerations have in public health policy and practice. One might ask, for instance, whether different circumstances in public health modulate the primacy of attending to questions of justice, where public health on the one hand operates *as* social justice, and on the other operates according to different aims (even different *moral* aims, like beneficence), that are constrained by social justice. One might ask whether the meaning and role of social justice in public health could be better understood in terms of *local* justice (Elster, 1993).

Previous research supports the idea that different goods—distribuenda—are governed by different principles of justice. For instance, Elster (1993) found that the allocation of organs for

transplantation, college admissions, and job layoffs tend to follow different allocative principles (i.e., need, merit, and seniority, respectively) in practice. As mentioned in Chapter 2, some theoreticians argue that this ‘separate spheres’ view is, in fact, a normative requirement of justice. This view, which might be more precisely described as a ‘goods-specificity’ view of justice, contends that the nature of a good dictates a certain principle of distribution (Elster, 1993). Walzer (1983), for instance, argues that injustice arises when a good is inappropriately converted into another good by the violation of ‘spheres’. An example would be when an affluent person uses her considerable resources (that were justly accumulated) to secure jobs for herself and her relatives. An injustice obtains on Walzer’s view because the principles governing the just apportionment of jobs ought to be governed by one’s merit, not their ability to pay.

What is interesting about my findings is that they represent perspectives on social justice within the context of two programmatic areas of public health—public health emergency preparedness and response and chronic disease prevention—which both ostensibly fall within what could be considered the ‘sphere’ of health. Yet, my findings indicate that the particular aims and activities of each programmatic area appear to influence the way in which social justice is perceived. Thus, it may be worth considering what social justice in public health might look like in a more granular formulation than what is supplied in a separate spheres view. While some might argue that this would tend to look like ‘health equity’ given its heightened focus on justice-based considerations with respect to health, I would argue that the previous section should cause us to resist this interpretation.

Even those who embrace the separate spheres view and focus specifically on the health sector, like Ruger (2010), for instance, fail to examine the particular nature, scope, and activities of different areas of public health practice in their assessment of social justice. Indeed, Ruger

does not distinguish justice questions in health care from justice questions in public health, let alone questions of justice that may obtain uniquely within different programmatic areas of public health. Other than those speculating about the more prominent utilitarian nature of public health emergency preparedness and response, no theoretician has explored this in depth. For those involved in public health policy and practice—those who may feel that many of the questions of social justice are more suitable for those working in ‘ministries of finance’ or who feel that social justice questions are beyond the role or scope of public health—details of the particular ways in which public health activities or programmatic areas should be organized and implemented to achieve the aims of social justice, or even whether their particular activities or area is *responsible* for contributing to these aims, may be unclear. This is an area in which theories of social justice, in their current forms, are mostly silent. Even theories that embrace the separate spheres view, like Ruger’s, remain more or less equally abstracted from consideration of the examination and explication of how particular public health activities and areas ought to be organized and implemented to achieve broader social justice aims. An area for future theoretical examination, therefore, is perhaps not in whether we should think about justice in terms of separate spheres, but rather in whether we should think about justice in terms of local context, aims, and activities. This seems to cohere with my prior point in section 6.2 regarding the need to examine the unique contributions that individual programmatic areas of public health can and should make towards realizing the broader aim that public health has as an institution to promote social justice.

#### **6.4 Study limitations**

The findings of this study must be considered in light of several limitations. One limitation concerns the challenges that existed in exploring the ways in which public health policy-makers talked about a complex subject like social justice. This study was a first attempt to understand

public health policy-makers' perspectives on the meaning of social justice and the role the value plays in relation to their practice, and so it was configured to be exploratory. Ultimately, through this explorative aim I attempted to strike a balance between explicitly exploring participants' perspectives on specific elements of social justice identified as being relevant and significant in the theoretical literature, and simply allowing participants to talk at length about their views about social justice as they relate to their practice. With respect to the former approach, I appreciated that there would be some utility in generating information about participants' views on particular elements that have been identified as important in the theoretical literature, such as the role of personal responsibility to justice, whether justice is interpreted in distributive, procedural, and/or relational terms, and so forth. However, I felt that, while this strategy might be capable of generating information about how participants perceived particular elements of social justice, it would do so at the risk of presuming those elements (and their perceptions of those elements) are relevant or play a role in how social justice is understood and used in practice. As such, I chose to primarily take my lead from participants in discussing the sorts of concerns and considerations that *they* chose to raise in response to my rather general probing questions about the meaning and role of social justice in their practice (and allowed my knowledge of the theoretical background of social justice to then explore the ideas, concerns, and perceptions raised by participants). This is a standard approach in exploratory qualitative studies, and particularly for what are described as 'conceptual interviews' (Brinkmann & Kvale, 2015). For example, instead of probing participants on the relevance of personal responsibility to social justice in public health, I asked open-ended questions where things like personal responsibility could be raised if participants considered them relevant to justice (e.g., "If some members of the public claimed they were treated 'unjustly' as a result of chronic disease prevention activities, what, in your opinion, do you think would make their claim justified?").

The result is that my study is limited in its ability to report the extent to which participants' perspectives about social justice align with the myriad elements and forms of social justice presented in Chapter 2. With that said, I believe the strategy adopted in this study is a strength insofar as it provided an enhanced understanding of the types of considerations that the term 'social justice' evoked for participants, which may better align with how they interpret and use the value in practice.

Another limitation associated with this exploratory aim concerns the fact that this study's findings do not attempt to provide an explanation for *why* public health policy-makers have the sorts of perspectives that they do. While some of the reasons and justifications that policy-makers had regarding their perspectives on social justice were generated during interviews, an explanation as to why their particular perspectives about justice exist, and the reasons and extent to which different areas of public health policy and practice might 'produce' particular perspectives about justice, were beyond the scope of this study. While comparisons, consequences, and relationships were explored, this was done in an interpretive manner by hypothesizing and speculating, rather than by explaining (Patton, 2001), and was pursued in light of the contextual dimensions that emerged as relevant or important in my data. Certainly, an understanding of the forces that influence public health policy-makers' perspectives on social justice is important, and ought to be explored in future studies.

Another limitation concerns the degree to which my study says something about public health policy-makers' perspectives about social justice *sensu stricto*. One might be inclined to argue that the things policy-makers said in my study about social justice are not all 'truly' perspectives on social justice, but rather perspectives on a constellation of values or on a separate value altogether. This is a common critique lodged by social psychologists who study social justice. That is, their research efforts are directed toward delimiting the scope of the subject

matter under study in order to best ensure that their studies are ‘valid’ insofar as they specifically and accurately generate information about people’s ‘justice beliefs’ (Jasso & Wegener, 1997; Swift, 1999). In other words, if researchers interested in this aim were to find that participants’ beliefs about beneficence, charity, or mercy were generated in response to data collection instruments, or that the responses participants supplied were motivated not by their ‘true’ beliefs about justice but rather by something like self-interest, they would consider this a flaw in the research methods. Yet, my study eschewed this concern (and aim) in favour of generating information about the ideas, concerns, or opinions that are invoked among public health policy-makers when social justice is discussed. My study was therefore not interested in participants’ beliefs (or perspectives) on social justice *sensu stricto*. My reasons for favouring this approach stem from my previously described methodological skepticism about the ability to ‘uncover’ participants’ ‘real’ beliefs, as well as my position that, from a practical standpoint, it is important to explore how this value is interpreted and used in practice irrespective of whether this corresponds with participants ‘true’ beliefs about social justice. Indeed, I believe that one of the strengths of this study is its ability to situate discussions of social justice in the context of other values, like health equity, in order to better understand the ecology of values at play in public health. That perspectives on social justice implicate other values, like health equity (and vice versa), is important to explore rather than attempting to delimit the scope of this inquiry to those perspectives that solely fall within the ‘proper’ scope of social justice.

Despite many important and interesting findings in this study, it was also ultimately limited in its ability to establish a more robust dialogue between ‘theory’ and ‘practice’ given the disparity between the depth, breadth, and sophistication of social justice discourse in the theoretical literature and the rather impoverished discourse of social justice in my interviews. As I articulated previously in this chapter, this discordance represents an important finding in and of

itself, though, and speaks to the need to enhance the level and quality of discourse surrounding social justice (and of the nature of ethics and values more generally) in public health policy and practice. By heeding my recommendations for theory to seek to establish greater *conceptual* clarity, as opposed to theoretical specification, and by combatting the view that rational dialogue, persuasion, and agreement about the meaning of social justice is impossible through enhanced public health ethics education, it is my hope that this study has provided insight into how this limitation may be overcome in the future.

My study involved interviews with individuals involved in policy and practice change in the specific programmatic areas of chronic disease prevention and public health emergency preparedness and response. While it is exceedingly uncommon for public health organizations to staff a ‘public health ethicist’ or someone who is specifically charged with examining and addressing ethical questions and issues, there may be individuals or divisions within public health organizations that are more involved in discussions, assessments, and applications of health equity and social justice. One could therefore argue that this study is limited because it did not engage those who may be more inclined in their work to contemplate the meaning and role of social justice. It would no doubt be important to engage these sorts of individuals (if they exist) in the future in order to understand their particular experiences and perspectives on the meaning and role of social justice. Certainly, exploring the perspectives of individuals from other areas of public health, or exploring perspectives on social justice from other sources of data (e.g., policies and documents) may reveal other ways in which social justice is conceptualized and used in public health. However, this is not to say that the interpretation and application of values in public health policy-making and practice resides solely within the purview of such individuals or divisions, if they even exist. As such, engaging public health policy-makers given

their involvement in policy and practice change in the programmatic areas of interest should be considered relevant and no less significant.

Finally, this study was limited by the small number of public health policy-makers interviewed and the purposeful selection of participants. The small number of policy-makers purposefully recruited and interviewed in this study allowed me to generate in-depth understandings of the perspectives of individuals situated in key roles who have unique insights into the meaning and role of social justice in relation to chronic disease prevention and public health emergency preparedness and response; however, pursuing this approach means that my findings should not be considered representative of the perspectives of all public health policy-makers, nor should they be considered statistically generalizable. However, unlike much quantitative research, which typically seeks to generalize findings, qualitative research commonly seeks illumination, understanding, and extrapolation to similar situations (Hoepfl, 1997). As such, this may be more accurately characterized as a study ‘delimitation’ rather than a study ‘limitation’. This study, like most qualitative research, provided an in-depth depiction and understanding of the social phenomena of interest—in this case the way in which social justice is understood in the context of public health policy and practice. Hence, its utility is in how this depiction and understanding may be similar or different to that which is operating in other contexts (Graneheim & Lundman, 2004). Whereas statistical generalizability tends to mask contextual factors (which are decidedly integral to this subject), the broader utility of this study’s findings can be found in their *transferability*; that is, in their ability to be used by researchers, policy-makers, and practitioners in understanding these findings in other contexts and settings (Lincoln & Guba, 1985; Shenton, 2004). The notion of transferability invites readers to engage with the contextual factors described in my findings (e.g., participants’ perceptions of the aims and activities of their work) and make connections between the findings of this study and their

experiences in other regions or contexts (Shenton, 2004). Ultimately, the findings of this study and their potential for transferability must be understood within the particular contexts in which they were generated (e.g., among public health policy-makers working in particular programmatic areas within public health organizations, as described in Chapter 4). One limitation of the transferability of these findings concerns the degree of contextual information generated regarding the jurisdictional level in which participants worked: municipal, provincial, or federal. By engaging participants on the aims and activities of ‘chronic disease prevention’ and ‘public health emergency preparedness and response’ as programmatic areas (which involved rather high-level discussions of the aims of these programmatic areas), less detail was generated about the activities and contextual features that may have been unique to the practice of public health at the municipal, provincial, and federal levels in these domains. As such, no unique themes were identified according to the level at which participants practiced. Certainly, the unique public health challenges, activities, and aims that might exist in other jurisdictional levels, regions, or programmatic areas may challenge the transferability of these findings. Future research to build on this study in other regions, other programmatic areas of public health, and with other public health professionals, will enable a more robust discussion of the transferability of these findings. In any case, this study could be considered as providing a ‘baseline understanding’ with which the results of subsequent studies and experiences should be compared (Gross, 1999). Ultimately, in order to enhance the transferability of my findings, and to be accountable to my data, I endeavored to describe and elucidate the notion of context throughout the study in order to enhance readers’ abilities to engage with my participants’ perspectives. By carefully articulating the analytic process that I followed in this study, I invite readers to interrogate the reliability of my interpretations through a deeper engagement with the research practices that produced them (Eakin & Mykhalovskiy, 2003).

## 6.5 Conclusion

The aim of this study was to explore the perspectives of public health policy-makers regarding the meaning of social justice and the role the value plays in the context of their practice. In addition, this study aimed to examine the extent to which the perspectives of public health policy-makers involved in different programmatic areas of public health (chronic disease prevention and public health preparedness and response) are similar or different in regards to the meaning and role of social justice. Finally, this study sought to identify and examine key areas in which these findings might help to enhance or refine normative social justice theory in public health, and in turn identify and examine key areas in which theory might help to enhance or refine the meaning and role of social justice in public health policy and practice. This study demonstrated that engaging with public health policy-makers regarding their perspectives on the meaning and role of social justice provides considerable insights into the ways in which social justice is interpreted and used by public health policy-makers.

Returning to this study's four research questions articulated in Chapter 4, the answer to the questions could be briefly summarized as follows:

1. What are public health policy-makers' perspectives on the meaning of social justice and the role the value plays in the context of their practice?

Answer: Participants perceived the meaning of social justice to be unclear and subject to personal interpretation. Its meaning in relation to participants' areas of public health practice was similarly perceived as unclear, and bordered on unrelated or un-relatable given their perception that it has not been 'operationalized' in a way that makes it practical. Participants indicated that social justice is not part of the normal discourse in their work. These interviews prompted discussions of 'health equity', which participants

suggested was ‘clearer’ and more commonly discussed as compared to social justice. Equity took on a particular meaning for participants: it focuses attention towards ‘proximal’ issues of disparities in access to public health programs and services, or to disparities in ‘materialistic’ determinants of health, like income. When asked to consider whether social justice means something different than equity, participants indicated that social justice focuses attention towards structural, societal issues that lead to disadvantage, such as sexism, racism, and issues of power. In theoretical terms, equity therefore seemed to invoke distributive justice considerations in terms of equitable access to resources and services, and social justice seemed to invoke relational justice considerations in terms of disadvantage. Whereas equity was characterized by participants as ‘objective’, ‘neutral’, ‘comfortable’, and ‘shallow’, social justice was described as ‘subjective’, ‘political’, ‘uncomfortable’, and ‘deeply embedded’. As a result, participants suggested that equity is easier to talk about and easier to ‘sell’, as discussions of social justice are constrained by political sensitivities, discomfort, and a disinclination to confront personal biases and positions of privilege. The findings from this study indicate that health equity dominates the discursive space wherein justice-based considerations are expressed in public health policy and practice.

2. To what extent are the perspectives of public health policy-makers involved in different programmatic areas of public health (chronic disease prevention and public health emergency preparedness and response) similar or different in regards to the meaning and role of social justice?

Answer: Participants’ perspectives on social justice appeared to be influenced by the perceived goals and contextual features that belong to the programmatic area of public health in which they practiced. As such, their perspectives on social justice differed in a

few key ways. Participants involved in public health emergency preparedness and response described this area's principal aims as saving the most lives and producing the greatest good, which were characterized as being synonymous with the 'public health approach'. Some described this as being just. Otherwise, justice-based considerations, interpreted almost entirely in terms of equity, as described above, were perceived as being external, or even as being impediments, to these consequentialist, if not utilitarian, aims. Participants involved in chronic disease prevention, on the other hand, described this area's central aims *in terms of* equity and justice; its purpose involves understanding and targeting the unique needs of different populations in order to produce equitable outcomes. Yet, participants in this domain acknowledged that equity, as construed above, does not focus attention towards upstream injustices, which ultimately determine inequities. These relational injustices, they suggested, were the domain of social justice. Participants involved in public health emergency preparedness and response did not make this distinction. In fact, they largely did not acknowledge considerations or concerns of justice outside of the distributive paradigm.

3. In what key areas should normative social justice theory in public health be enhanced or refined given this study's empirical findings?

Answer: Existing accounts of social justice that concern themselves with questions of social justice in public health fail to consider the unique justice-based considerations or concerns that may manifest in particular contexts or programmatic areas of public health. Given the variable and expansive nature and scope of public health activities, the findings from this study point to the possible benefits of complementing the search for a universal, coherent account of social justice to guide and justify public health activities in favour of examining the ways in which social justice considerations and aims ought to manifest in

particular programmatic areas of public health. In particular, this study's empirical findings enjoin normative theory to consider not whether justice ought to be viewed as either 'universal' or in 'separate spheres', but rather whether and how it ought to be understood when situated and pursued within particular contexts of public health policy and practice. While existing theories of social justice may be instructive or useful in framing how the broader aims of public health as an institution ought to be designed, given that different programmatic areas of public health likely each contribute something unique to this aim, the implications that these theories have for the context-specific aims and activities in particular programmatic areas of public health require further thought and specification. In particular, normative theory ought to examine the specific ways that different activities, like chronic disease prevention and public health emergency preparedness and response, are conceptually and practically linked to broader social justice aims.

4. Given this study's empirical findings, in what key areas might normative social justice theory help to enhance or refine the meaning and role of social justice in public health policy and practice?

Answer: In contrast to advancing specific accounts of social justice, normative theory in this area might help to enhance or refine how social justice is understood and used in public health policy and practice by delimiting the particular nature and scope that social justice considerations ought to take in public health. Hence, normative theory could be used to establish greater *conceptual* clarity, rather than strictly theoretical specification. This could in turn translate into practical tools that attune attention towards the relevant considerations and questions that are central to social justice in public health. In addition, it may be particularly important to explore how Powers and Faden's Structural Fairness

Aim of justice, as well as other thinking around disadvantage, can be translated and incorporated into public health policy and practice in order to affirm or emphasize disadvantage as a distinct normative concern of social justice. Finally, normative theory, in conjunction with knowledge translation efforts, could be used to transform a ‘you know it when you see it’ attitude towards the identification of social injustice in public health into a critical outlook of ‘you see it when you know it’.

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## Appendix I

### Empirical literature search strategy

This literature search was conducted in May of 2015 (and updated in May 2016) using two searches, each with distinct strategies. The first search, which I will call the ‘narrow search’, aimed at identifying any literature that had explored or addressed this study’s concept of interest—social justice—within the context of interest—public health policy and practice—using empirical methods capable of generating data about the perspectives of individuals or organizations. As such, the narrow search was designed to quickly identify whether any literature had addressed this study’s research questions, in addition to identifying the body of literature most relevant to the pursuit of this study’s objectives. To accomplish this task, this search was conducted with key words and parameters of relatively straightforward and narrow foci.

#### **Search 1: Narrow search criteria:**

1. Has the term ‘justice’ in the title or abstract
2. Has the term ‘public health’ in the title or abstract
3. Has at least one of the following empirical terms in the title or abstract: ‘survey(s)’; ‘questionnaire(s)’; ‘quantitative’; ‘interview(s)’; ‘informant(s)’; ‘focus group(s)’; ‘document(s)’; ‘qualitative’; ‘case study(ies)’; ‘empirical’
4. Published in English
5. No restrictions on publication or study location, date, or venue/type

The narrow search was conducted within the US National Library of Medicine MEDLINE database using the PubMed search engine, and replicated in the JSTOR database.

The second search, which I will call the ‘broad search’, aimed to capture a broader body of literature by including several other justice-related terms. All search criteria were the same as in the narrow search except for the first criterion.

**Search 2: Broad search criteria:**

1. Has at least one of the following justice-related terms in the title or abstract: ‘justice’; ‘injustice’; ‘equity’; ‘inequity’; ‘inequities’; ‘fairness’; ‘unfairness’;
2. Has the term ‘public health’ in the title or abstract
3. Has at least one of the following empirical terms in the title or abstract: ‘survey(s)’; ‘questionnaire(s)’; ‘quantitative’; ‘interview(s)’; ‘informant(s)’; ‘focus group(s)’; ‘document(s)’; ‘qualitative’; ‘case study(ies)’; ‘empirical’
4. Published in English
5. No restrictions on publication or study location, date, or venue/type

The broad search was conducted within the US National Library of Medicine MEDLINE database using the PubMed search engine.

Finally, ancillary search strategies were conducted in order to capture other relevant literature not identified by either of the previously described searches. These strategies included the review of bibliographies from literature included in the review, as well as manual searches of journals deemed of high relevance to the domain of this study (e.g., ‘*Public Health Ethics*’, ‘*Social Justice Research*’).

## Appendix II

### Research ethics board approval letter



OFFICE OF THE VICE-PRESIDENT,  
RESEARCH AND INNOVATION

PROTOCOL REFERENCE # 29816

January 24, 2014

Dr. Ross Edward Upshur  
INST FOR HIST & PHIL OF SCI & TECH  
FAC OF ARTS & SCIENCE

Mr. Maxwell Smith  
INST FOR HIST & PHIL OF SCI & TECH  
FAC OF ARTS & SCIENCE

Dear Dr. Upshur and Mr. Maxwell Smith,

Re: Your research protocol entitled, "Just what is Just in public health? A qualitative study of public health policy-maker perspectives"

---

**ETHICS APPROVAL**

**Original Approval Date: January 24, 2014**

**Expiry Date: January 23, 2015**

**Continuing Review Level: 1**

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We are writing to advise you that the Health Sciences Research Ethics Board (REB) has granted approval to the above-named research protocol under the REB's delegated review process. Your protocol has been approved for a period of **one year** and ongoing research under this protocol must be renewed prior to the expiry date.

**Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.**

**Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.**

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

**OFFICE OF RESEARCH ETHICS**

McMurrich Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada

Tel: +1 416 946-3273 • Fax: +1 416 946-5763 • [ethics.review@utoronto.ca](mailto:ethics.review@utoronto.ca) • <http://www.research.utoronto.ca/for-researchers-administrators/ethics/>

## Appendix III

### Participant consent form

**Project Title:** Just what is *just* in public health? A qualitative study of public health policy-maker perspectives

**Principal Investigator:** Mr. Maxwell Smith  
 PhD Candidate, Dalla Lana School of Public Health  
 Graduate Student Member, Joint Centre for Bioethics  
 University of Toronto  
 155 College Street, Suite 549  
 Toronto, ON M5T 3M7  
 Email: [max.smith@utoronto.ca](mailto:max.smith@utoronto.ca)  
 Phone: 416-875-7055

**Co-Investigators:** Dr. Ross Upshur (Supervisor), Dr. Alison Thompson, Dr. Angus Dawson

**Sponsor:** Canadian Institutes of Health Research

#### **Preamble:**

You are being invited to participate in an interview to discuss the meaning and role of social justice in [area of public health practice]. Before deciding whether or not you wish to participate, it is important that you understand the project. This consent form describes the purpose, procedures, and potential harms and benefits of this project. It also describes your right to refuse to participate or to withdraw from the interview at any time without penalty. Please ask the interviewer to explain any terms you do not understand and make sure all your questions are answered to your satisfaction before signing this consent form.

#### **Background:**

This study focuses on how public health policy-makers view the concept and role of social justice in [area of public health practice]. You are being invited to participate in this project because you have been identified as someone who is knowledgeable in this area of public health and who may be able to speak to the subject matter. Your participation is important and will contribute to research that is intended to affect public health policy and practice.

#### **Procedures:**

If you agree to participate, you will be asked about your views on questions related to the goals of public health policy and practice and the role of the value 'social justice' in your area of practice. The interview will take approximately 60 minutes. The interview will be digitally recorded and transcribed. Only the principal investigator will have access to the audio recording and only the research team identified above will have access to the transcript. All digital files will be kept on a password-protected computer and all paper copies of the transcripts will be kept in a locked cabinet and will be shredded at the completion of the study. Your decision to

participate or to not participate will be kept in strict confidence. All personal information will be removed from the transcripts and you will not be identified in any reports, publications, or presentations. At the commencement of the interview you will be reimbursed for any travel-related expenses incurred for participating in this study in addition to a \$10 gift certificate to a local coffee shop as a token of appreciation for your participation.

**Potential Harms and Benefits:**

There are no physical risks associated with participating in this project. If any of the interview questions make you feel uncomfortable in any way, you may choose not to respond. You may stop participating in the interview or withdraw from the project at any time without having to explain any reasons, and without any consequences of any kind.

This project will not benefit you directly; however, it has the potential to improve public health policy and practice. You do not give up any of your legal rights by participating in this project. Your privacy and confidentiality will be respected throughout the project. Your employer will not have access to the data you provide. Your name will not be attached to any comments you make during the interview so there will be no way for anyone to attribute your comments to you.

**Publication of Research Findings:**

The results of these findings may be published in academic journals, presented at academic conferences, and used for education purposes to the extent that this would further an understanding of these issues. Your identity or any other potentially identifying information will not be revealed in any publication.

**Contacts:**

If you have any questions or concerns, please contact Mr. Max Smith by e-mail at max.smith@utoronto.ca or by telephone at 416-875-7055. You will be provided a copy of this consent form at the interview. If you have questions about your rights as a research participant, please contact the Office of Research Ethics at the University of Toronto (e-mail: ethics.review@utoronto.ca or telephone: 416-946-3273).

**Consent:**

I understand that my participation in this project is voluntary and that I may withdraw at any time without penalty. I have received a copy of this signed consent form. I have read and understood the above information and agree to participate in this project.

\_\_\_\_\_  
Participant Name (please print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

.....

I have explained the project and obtained the informed consent of the above-named participant.

\_\_\_\_\_  
Investigator Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Appendix IV

### Participant recruitment email

Subject: Invitation to participate in University of Toronto research project on justice and public health

Dear [name of potential participant],

I would like to invite you to participate in an interview to discuss the meaning and role of ‘social justice’ in the context of your work in public health. The University of Toronto is conducting a study about how individuals involved in developing and implementing policy view the role that considerations of social justice and injustice have in [public health emergency preparedness and response *or* chronic disease prevention].

You have been identified as someone who is knowledgeable in this area of public health and who may be able to speak to this subject matter. As a member of [name of public health organization], your participation is important and will contribute to research that is intended to affect public health policy and practice.

The interview will last approximately 45-60 minutes. I have attached a copy of the consent form, if you’d like to read it. I will also be bringing a copy of the consent form to the interview. If you have any questions, please feel free to contact me at [max.smith@utoronto.ca](mailto:max.smith@utoronto.ca) or at 416-875-7055.

**\*\*Please note that your participation is completely voluntary; there is no penalty for declining this invitation and no one will be made aware if you decline.**

If you would like to participate, please suggest some dates and times that work best for you.

Thank you for your time and assistance. I look forward to speaking with you soon.

Sincerely,

Max Smith  
Ph.D. Candidate, Dalla Lana School of Public Health  
University of Toronto  
[max.smith@utoronto.ca](mailto:max.smith@utoronto.ca)  
416-875-7055

## Appendix V

### Semi-structured interview guides

#### **Semi-structured interview guide: Chronic disease prevention**

1. I'd like to begin by asking you to briefly describe your role and some of the work you do at [public health organization].
2. Diverse things like cancer, mental illness, diabetes, and cardiovascular disease have all been considered issues of concern for what public health calls 'chronic disease prevention'. What do you think makes something a 'chronic disease'?
3. What would you say is or are the main purposes or goals of chronic disease prevention? What is it that you are you trying to achieve?
4. Can you think of a situation or outcome in your work in public health that you would characterize as 'unjust' or 'unfair'?
  - What do you think made that situation/outcome 'unjust' or 'unfair'?
  - If some members of the public claimed they were treated 'unjustly' as a result of chronic disease prevention measures, what, in your opinion, do you think would make their claim justified?
5. In the Public Health Agency of Canada's "core competencies necessary for the practice of public health", it states that "social justice" is an important value in public health.
  - What do you take this concept to mean for your practice?
  - In your experience, what role do you think the concept of social justice plays in chronic disease prevention, if any?
    - Probe: What role do you think considerations of social justice *should* play in chronic disease prevention?
  - How would you say social justice is operationalized in chronic disease prevention?
  - The core competency statement also identifies "equity" as an important value for public health. Do you consider equity to be different from social justice?
6. Can you think of a time when you felt a policy or practice in chronic disease prevention achieved, or attempted to achieve, social justice?
7. Chronic diseases are often quite complex and are often created or sustained by many factors. In your experience, in what ways do you think having a commitment to social justice affects, or would affect, the ability to achieve the goals of chronic disease prevention?
8. It is often expressed that public health policy and practice should be "evidence informed" or "evidence based". If you were to assess the extent to which a policy or practice in your

work in public health promotes social justice, what do you think we should be measuring (or considering) in that assessment?

9. Wrap-up questions

- Given this topic of ‘social justice’, are there any other questions you think I should ask or comments you’d like to make?

**Semi-structured interview guide: Public health emergency preparedness and response**

1. I’d like to begin by asking you to briefly describe your role and some of the work you do at [public health organization].
2. Diverse things like pandemics, ice storms, and floods have been called ‘public health emergencies’. Some people even call ‘obesity’ a public health emergency. What do you think makes something a ‘public health emergency’?
3. What would you say is or are the main purposes or goals of public health emergency preparedness and response? What is it that you are you trying to achieve?
4. Can you think of a situation or outcome in your work in public health that you would characterize as ‘unjust’ or ‘unfair’?
  - What do you think made that situation/outcome ‘unjust’ or ‘unfair’?
  - If some members of the public claimed they were treated ‘unjustly’ as a result of public health emergency preparedness and response measures, what, in your opinion, do you think would make their claim justified?
5. In the Public Health Agency of Canada’s “core competencies necessary for the practice of public health”, it states that “social justice” is an important value in public health.
  - What do you take this concept to mean for your practice?
  - In your experience, what role do you think the concept of social justice plays in public health emergency preparedness and response, if any?
    - Probe: What role do you think considerations of social justice *should* play in public health emergency preparedness and response?
  - How would you say social justice is operationalized in public health emergency preparedness and response?
  - The core competency statement also identifies “equity” as an important value for public health. Do you consider equity to be different from social justice?
6. Can you think of a time when you felt a policy or practice in public health emergency preparedness and response achieved, or attempted to achieve, social justice?
7. Public health emergencies create practical challenges for an effective response. In your experience, in what ways do you think having a commitment to social justice affects, or would affect, the ability to achieve the goals of public health emergency preparedness and response?

8. It is often expressed that public health policy and practice should be “evidence informed” or “evidence based”. If you were to assess the extent to which a policy or practice in your work in public health promotes social justice, what do you think we should be measuring (or considering) in that assessment?
9. Wrap-up questions
  - Given this topic of ‘social justice’, are there any other questions you think I should ask or comments you’d like to make?

## Copyright acknowledgements

Section 2.3.2 of this thesis contains text extracted from my own previously published materials:

Smith, MJ. (2015). Health equity in public health: Clarifying our commitment. *Public Health Ethics*, 8(2), 173-184. doi: 10.1093/phe/phu042.

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