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Implementing Health Impact Assessment as a Required Component of Government Policymaking: A Multi-Level Exploration of the Determinants of Healthy Public Policy

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A thesis submitted in partial fulfillment of the requirements for the Doctor of Philosophy degree in Health Information Science

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Abstract

It is widely understood that the public policies of ‘non-health’ government sectors have greater impacts on population health than those of the traditional healthcare realm. Health Impact Assessment (HIA) is a decision support tool that identifies and promotes the health benefits of policies while also mitigating their unintended negative consequences. Despite numerous calls to do so, the Ontario government has yet to implement HIA as a required component of policy development. This dissertation therefore sought to identify the contexts and factors that may both enable and impede HIA use at the sub-national (i.e., provincial, territorial, or state) government level.

The three integrated articles of this dissertation provide insights into specific aspects of the policy process as they relate to HIA. Chapter one details a case study of purposive information-seeking among public servants within Ontario’s Ministry of Education (MOE). Situated within Ontario’s Ministry of Health (MOH), chapter two presents a case study of policy collaboration between health and ‘non-health’ ministries. Finally, chapter three details a framework analysis of the political factors supporting health impact tool use in two sub-national jurisdictions – namely, Québec and South Australia.

MOE respondents (N=9) identified four components of policymaking ‘due diligence’, including evidence retrieval, consultation and collaboration, referencing, and risk analysis. As prospective HIA users, they also confirmed that information is not routinely sought to mitigate the potential negative health impacts of education-based policies.

MOH respondents (N=8) identified the bureaucratic hierarchy as the brokering mechanism for inter-ministerial policy development. As prospective HIA stewards, they also confirmed that the ministry does not proactively flag the potential negative health impacts of non-health sector policies. Finally, ‘lessons learned’ from case articles specific to Québec (n=12) and South Australia (n=17) identified the political factors supporting tool use at different stages of the policy cycle, including agenda setting (‘policy elites’ and ‘political culture’), implementation (‘jurisdiction’), and sustained implementation (‘institutional power’).

This work provides important insights into ‘real life’ policymaking. By highlighting existing facilitators of and barriers to HIA use, the findings offer a useful starting point from which proponents may tailor context-specific strategies to sustainably implement HIA at the sub-national government level.

Keywords

Health Impact Assessment; HIA; Healthy Public Policy; Policy Development; Information Seeking; Health Information Science; Provincial Government; Bounded Rationality; Normative Institutionalism

Summary for Lay Audience

The public policies developed and implemented by several government ministries determine whether we experience good or poor health throughout our lives. Health Impact Assessment (HIA) is a tool used to ensure that public policies are beneficial rather than detrimental to our health. The Ontario government does not require HIA to be used as part of policy development. This dissertation identifies the contexts and factors that support or prevent HIA use at the provincial, territorial, or state government levels.

This dissertation consists of three studies. The first explores how policy staff search for the information needed to develop policies within Ontario’s Ministry of Education. The second describes how policy staff within Ontario’s Ministry of Health interact with other ministries to co-develop policies. The third identifies ‘what works’ to support health impact tool use within two regions like Ontario in order to adopt similar approaches.

Nine respondents from the Ministry of Education identified four tasks routinely undertaken as part of policy development, including collecting evidence, consulting and collaborating, referring to existing policies, and identifying the possible risks of proposed policies. They also confirmed that the Ministry does not require them to collect information for the purpose of preventing the possible negative health impacts of their policies. Seven respondents from the Ministry of Health identified a vertical approval

process through which interactions between ministries are approved. They also confirmed that the Ministry does not typically inspect the policies of other ministries in order to prevent their possible negative health impacts. Finally, health impact tool use in both Québec and South Australia was initially supported by individuals with expertise in health policy ('policy elites'), as well as shared value placed on preventing health problems before they occur ('political culture'). The ongoing use of these tools was supported by efforts to preserve longstanding roles and responsibilities within government sectors ('jurisdiction'), as well as rules and requirements to ensure that impact assessments are conducted ('institutional power').

Together this work offers a blueprint for action among individuals or groups who would like to see HIA used in the development of sub-national government policies.

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1 Introduction

This dissertation seeks to open the “black box” of policy development to identify the contexts and factors conducive to implementing health impact assessment (HIA) as a required component of provincial policy development. Accordingly, each of its three integrated articles provides in-depth insight into a specific aspect of the policy process as it relates to HIA. Chapter one details a case study of purposive information-seeking as conducted by public servants within Ontario’s Ministry of Education. Given the centrality of information to both public policy and HIA, the Ministry-specific rules, norms, and values (i.e., ‘institutions’) shaping routine search processes are of particular interest. Chapter two then presents a case study of policy collaboration between health and ‘non-health’ Ministries of the Ontario government. As prospective stewards of a provincial HIA protocol, specific focus is given to Ministry of Health staff perceptions of their own ‘boundary spanning’ roles, as well as any predominant views of the Ministry’s policy purview more generally. Finally, chapter three presents a Framework Analysis of the conditions sufficient for HIA use at the sub-national level. To do so, Québec and South Australia are identified as two exemplary jurisdictions in which health impact tools have been institutionalized. Analysis of the political factors surrounding their use is guided by a glossary by Oneka et al. (2017), thereby moving beyond an organizational focus to explore the broader contexts and mechanisms (e.g., ideology, political support) conducive to the adoption and sustained implementation of HIA.

This introductory chapter provides a brief overview of the key concepts underscoring this dissertation, as well as its purpose, research questions, and relevance.

1.1 Background

The following details the key concepts upon which this research is founded – that is, the social determinants of health, healthy public policy, Health in All Policies, and HIA. Each is discussed in greater detail within the subsequent integrated articles of this dissertation.

1.1.1 Healthy Public Policy as a Determinant of Health

The structural determinants of health, including public policies, are key mechanisms through which our living conditions are created, modified, and sustained (Solar & Irwin, 2010). These living conditions comprise the social determinants of health (SDoH) – a series of complex and interrelated factors, including education, employment and working conditions, gender, race, food security, and housing (Raphael, 2016). The upstream distribution of the SDoH shape the downstream priorities of biomedical (e.g., access to medical care) and behavioural (e.g., lifestyle change) approaches (Woolf & Braveman, 2011). Although healthcare and behavioural risk factors play important roles in shaping health status, the policies of non-health government sectors ultimately have greater impact on population health (de Leeuw & Clavier, 2011).

As Dr. Trevor Hancock once asserted, “if we are going to make more advances in the health of the public... it can only be through recognizing the important role of public policy in non-health sectors in creating the conditions for health or disease” (1985, p.11). The concept of *healthy public policy* thus entails a holistic approach to shaping future health by challenging the “fixed” nature of existing social and environmental structures. This approach contrasts that of *health policy*, whereby socio-cultural systems are accepted as givens, and health problems are addressed through secondary and tertiary intervention (Hancock, 1985). This distinction is espoused by the Public Health Agency of Canada (PHAC), which locates healthy public policy and clinical approaches at opposite ends of the prevention spectrum. Specifically, clinical prevention commonly entails one-on-one interventions between health specialists and care recipients – the latter of whom adhere to professional recommendations at their own discretion. Conversely, healthy public policy entails direct intervention on the SDoH, *without health functioning as the main policy objective* (PHAC, 2009). A critical aspect of this approach is thus a recognition of the ways broader policy contexts, comprised of non-health sectors, shape and ultimately determine individual and population health outcomes (Chircop et al., 2015; Raphael, 2016).

1.1.2 Health in All Policies (HiAP)

Launched during the Finnish Presidency of the European Union in 2006, HiAP is “*an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health*” (World Health Organization [WHO], 2014, p.7).

HiAP is founded on the principles of legitimacy, accountability, transparency, participation, sustainability, and collaboration (WHO, 2014). The collaborative component in particular is supported by formalized governance structures, thereby distinguishing it from other intersectoral approaches.

HiAP stems from a series of seminal frameworks which, over nearly 50 years, have emphasized the need to address factors beyond direct biomedical and healthcare realms in order to improve population health (Clavier & de Leeuw, 2013). As an increasingly predominant framework aligned with the SDoH approach (WHO, 2014), its core principles may be traced as far back as Canada’s Lalonde Report (1974), considered by some as the West’s first national policy to formally acknowledge the potentially profound health implications of social and physical environments (de Leeuw & Clavier, 2011; Hancock, 1985). Others have identified HiAP’s roots within the Alma-Ata Declaration (1978) and Ottawa Charter for Health Promotion (Ståhl, 2018) and, more recently, the Commission on the Social Determinants of Health (2008) and the Rio Declaration (2011) (Kokkinen et al., 2017). Together these are described by the Helsinki Statement on HiAP as “a rich heritage of ideas, action, and evidence” upon which HiAP as a “major goal for governments” is founded (WHO, 2014, p.1).

1.1.3 Health Impact Assessment

Although the methodological design, purpose, and application of HIA are highly context specific (Harris-Roxas & Harris, 2011), it is commonly defined as “*a combination of procedures, methods and tools by which a policy ... may be judged as to its potential effects on the health of a population, and the distribution of those effects*” (WHO, 1999, p.4). Rather than prescribing health-related decisions, HIA proposes actions to both

maximize the health benefits of public policies, as well as mitigate their potential negative impacts. Accordingly, it may be used on an *ad hoc* basis or as part of a broader HiAP framework. In either case, it functions as a governance tool to facilitate intersectoral engagement and direct non-health sector attention toward the determinants of health (Linzalone et al., 2018). It is thus deemed by some to be a highly structured step toward HiAP (e.g., Harris-Roxas & Harris, 2011; St-Pierre, 2009).

The structured components of HIA generally include: 1) *Screening* evidence to determine whether an assessment is appropriate; 2) *Scoping* its details; 3) *Assessing* the policy to identify and characterize health impacts, and develop strategies to promote positive and mitigate negative outcomes; 4) *Reporting* key findings of the previous step; 5) *Monitoring* the accuracy of predictions and the effectiveness of promotion or mitigation strategies; and 6) *Evaluating* the HIA process for future improvement (McCallum et al., 2015). There is, however, notable jurisdictional variation in terms of when the assessment process is undertaken – that is, *prior to* or *following* the drafting of policy proposals (Quigley, 2010). In either case, governments may avoid introducing a degree of foreseeable harm to population health through public policies.

1.2 Relevance: The Canadian Context

Linzalone and colleagues recently identified at least 20 international regions demonstrating some degree of HIA implementation (Linzalone et al., 2018). Although Canada has long been considered an international “health promotion powerhouse” (Mikkonen & Raphael, 2010, p.7), meaningful progress surrounding HIA remains sparse at both the national and provincial/territorial levels. In the late 1990s, for example, Health Canada released *The Canadian Handbook on Health Impact Assessment* amidst growing interest in HIA. After two subsequent volumes, however, the handbook was permanently archived in 2013 (McCallum et al., 2015). Most recently, the federal Impact Assessment Act (2019) modified the scope of health considerations required to inform federally-mandated environmental impact assessments (EIAs) – the tool from which HIA is derived. Whereas EIAs previously entailed a narrow focus on biomedical health

determinants (McCallum et al., 2015), they now require analysis of the potential impacts of policies or projects on the SDoH and Indigenous health (Freeman, 2019).

While the above efforts highlight some notable progress at the federal level, it is Canada's 13 provincial and territorial governments that possess significant policy and legislative authority over key SDoH. It is therefore noteworthy that Québec remains the only province to achieve some degree of HIA institutionalization, having integrated a health impact requirement into its provincial Public Health Act (2002) (Lysyk, 2019). While other provinces, including Ontario, have demonstrated some notable interest (e.g., Lysyk, 2019; Shankardass et al., 2011), efforts to keep HIA on the government agenda have continually stagnated. As such, there remains significant potential to enhance provincial efforts to both promote and protect population health.

1.3 Research Purpose

This dissertation seeks to open the “black box” of policy development to identify the contexts and factors conducive to implementing health impact assessment (HIA) as a required component of provincial policy development. Together its findings provide a useful foundation for proponents seeking to effectively integrate HIA into existing policy structures and processes within the Ontario government.

1.4 Research Questions

Chapter one details a single holistic case study of the contexts and factors shaping purposive information-seeking within Ontario's Ministry of Education. This Ministry was chosen due to its authority over a critical modifiable determinant of health – that is, education-based policy. Given the centrality of information to HIA and policymaking alike, the organization-specific contexts and factors shaping routine information retrieval were of particular interest. By exploring the “black box” of *intra-ministerial* policy development, this study additionally established a baseline for HIA integration efforts – that is, existing facilitators of, and barriers to, HIA implementation. Two research questions are asked:

1. How and to what extent do individual and organization-level determinants interact to shape purposive information seeking to inform intra-ministerial policy development?
2. What structures, processes, or mechanisms are in place to enable or impede HIA implementation at the provincial level?

Set within Ontario's Ministry of Health, chapter two details a single holistic case study of the traditional nature of policy collaboration between health and 'non-health' ministries. By exploring the "black box" of *inter-ministerial* policy development, this study additionally identifies existing facilitators of, and barriers to, HIA implementation. Two research questions are asked:

1. How and to what extent do individual-and organization-level determinants interact to shape routine inter-ministerial policy development between health and 'non-health' ministries of the Ontario government?
2. What structures, processes, and mechanisms are in place to enable or impede HIA implementation at the provincial level?

Chapter three explores the political factors surrounding the adoption and sustained implementation of health impact tools in Québec and South Australia. Lessons learned may inform policy transfer efforts across sub-national 'emulator' regions seeking to implement similar health impact approaches. Two research questions were asked:

1. What jurisdiction-specific political mechanisms have contributed to the adoption and sustained implementation of health impact tools *within* the sub-national regions of Québec and South Australia?
2. What political mechanisms have consistently contributed to the adoption and sustained implementation of health impact tools *across* the sub-national regions of Québec and South Australia?

1.5 Relevance to Health Information Science

While the health implications of non-health government sectors are now well-established, there remains considerable variation in the uptake of formalized HIA protocols at the sub-national level. This is especially noteworthy within the Canadian context given the near exclusive policy and legislative authority provincial and territorial governments possess over key SDoH.

Recent focus on impact assessment tools generally, and HIA in particular, highlights their parallels to the Evidence-Based Policy (EBP) movement (e.g., Feyaerts et al., 2017; Lyhne et al., 2021). That is, both HIA and EBP seek to increase the scope of evidence that directly informs policy, with the expectation that “enhancing the information basis of policy decisions will improve results flowing from their implementation” (Howlett, 2009, p.157). Where HIA is conducted prospectively, its first three steps (i.e., screening, scoping, and assessment) may inform policy development such that each proposed alternative accounts for the impacts so identified. To do so first requires that population health outcomes are understood to fall within the purview of ‘non-health’ sectors. Moreover, policy actors must be able and willing to seek health information for the explicit purpose of mitigating potential harm. Finally, governance mechanisms are needed to both integrate health information into policy development, and uphold government-wide accountability in doing so. The present dissertation explores these preconditions by opening the proverbial “black box” of policy development and related decision processes – that is, *how* policymaking occurs, and *why* it occurs as such. A better understanding of the ‘realities’ of intra-and inter-ministerial policy processes, combined with ‘lessons learned’ from two sub-national jurisdictions, provide a practical starting point from which Ontario may enhance the health of its population through evidence-informed healthy public policies.

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CHAPTER 1

2 Purposive information seeking to support evidence-informed policy within Ontario's Ministry of Education: How might existing structures and processes facilitate or impede a provincial Health Impact Assessment protocol?

The structural determinants of health, including public policies, are key mechanisms through which our living conditions are created, modified, and sustained (Solar & Irwin, 2010). These conditions in turn comprise the *social determinants of health* (SDoH) – a series of complex and interrelated factors including, but not limited to, education, employment and working conditions, gender, race, food security, and housing (Raphael, 2016). The *upstream* distribution of the SDoH shape the *downstream* priorities of biomedical (e.g., access to medical care) and behavioural (e.g., lifestyle change) approaches (Woolf & Braveman, 2011). Although healthcare and behavioural risk factors play important roles in shaping health status, the public policies of non-health government sectors ultimately have greater impact on population health (de Leeuw & Clavier, 2011; Woolf & Braveman, 2011).

The *life course* perspective highlights the cumulative nature of the SDoH, whereby early childhood conditions have lasting impact on disease onset and health maintenance across one's lifespan (Raphael, 2016). In light of this effect, education is one of the most important modifiable determinant of health, as healthier individuals generally achieve higher educational success, and those with more education tend to lead healthier lives (Basch, 2011; "Education", 2020). Within school settings, this relationship may be fostered in different ways. For example, tailored educational programs can equip students with knowledge and skills to prevent disease (e.g., nutrition education) and enhance their own health (e.g., health literacy) (Kawachi et al., 2010). However, as Basch (2011) observes, "educational progress will be profoundly limited if students are not motivated and able to learn" (p.593). In this regard, the World Health Organization (WHO) also emphasizes the importance of the educational institution itself, wherein a number of

factors ranging from school culture and management to the quality of the physical and social environments, curriculum design, and approaches to testing and assessment all have “a direct effect on self-esteem, educational achievement and, consequently, the health of students and staff” (Jones & Furner, 1998, p.2). The public policies that shape student learning experiences therefore have significant and lasting potential for population health impact.

Health in All Policies (HiAP) is a predominant overarching framework aligned with the SDoH approach (Kickbusch, 2013). It is founded on a series of seminal health frameworks which, over nearly 50 years, have emphasized the need to address factors beyond direct biomedical and healthcare realms in order to improve population health (e.g., WHO, 2014). To do so, each highlights the centrality of public policy in amending the broad determinants of health, and the need for concerted action across government sectors “to counter the enduring conflation of health with healthcare” (Clavier & de Leeuw, 2013, p.3). Accordingly, HiAP is comprised of two key components. The first entails developing or amending policies to *improve* health according to population need. The second seeks to systematically identify and promote the positive health impacts of public policies while at the same time *mitigating* potential negative outcomes (Fafard, 2013). The key difference between these components is their respective scope of consideration, with the latter seeking to address the broad SDoH rather than explicit health problems (National Collaborating Centre for Healthy Public Policy [NCCHPP], 2017).

The potential negative health implications of public policies may be identified and mitigated through use of a Health Impact Assessment (HIA) tool. Despite its various methodological designs and applications, HIA may be defined as *a combination of procedures, methods and tools that systematically judges the potential unintended effects of a policy ... on the health of a population ... and identifies appropriate actions to manage those effects* (WHO, 1999, p.1). As such, HIA may be conducted on an ad hoc basis or as part of a broader HiAP framework. In either case, it functions as a governance tool to facilitate intersectoral engagement and direct non-health sector attention toward

the determinants of health (Linzalone et al., 2018). It is thus considered by some to be a highly structured approach toward HiAP (e.g., St-Pierre, 2009).

With the exception of Québec, HIA has yet to be implemented by provincial and territorial governments across Canada (Linzalone et al., 2018). In Ontario, a Health Equity Impact Assessment (HEIA) toolkit was developed in 2012 for use among provincial health care systems, regional health service providers, and government ministries (Ministry of Health and Long-Term Care [MOHTLC], 2012). However, evidence of its uptake remains unclear. In 2019, Ontario's Auditor General noted that, following efforts to gauge its feasibility, the provincial Ministry of Health planned to implement "an approach that requires policymaking to evaluate [a policy's] impact on health, where appropriate" (Lysyk, 2019, p.149). This decision would align with recommendations previously put forth by a number of public health entities (e.g., Ontario Public Health Association, 2014; Ontario Chronic Disease Prevention Alliance, 2018). As with HEIA, however, the details of this more recent approach, including its implementation and extent of use across government, also remain unclear. As such, the public policies of non-health sectors may continue to risk introducing unintended negative consequences to population health.

The present study therefore sought to explore routine policy development within the Ontario government to account for the variable uptake of HIA across regions (Linzalone et al., 2018). Given the centrality of *information* to both public policy and HIA, a case study was conducted to better understand the judgments and decisions that guide purposive information seeking to support evidence-informed policy. The case study focused on policy development within Ontario's Ministry of Education due to its mandated jurisdiction over education-related policy and legislation, and thus its significant authority to create, modify, and sustain what is empirically recognized as one of the most important modifiable determinant of health.

2.1 Health Impact Assessment as a Policy Formulation Tool

The *stages model* divides the policy process into the distinct components of problem recognition, alternative generation, decision making, implementation, and evaluation (Howlett et al., 2009). Although considered an oversimplification of what is widely recognized as a ‘messy’ and ‘iterative’ process, the model remains a popular heuristic in recognition of the conceptual and analytical clarity it provides (Craft, 2012; Fafard, 2008).

HIA is often conducted prospectively to inform *policy development* (Harris et al., 2014; Quigley, 2010). It is thus useful to discern this stage from *agenda setting*, defined as “the process by which the issues that an organization sees as critical for current decision making are chosen” (Workman et al., 2009, p.79). Policy development has traditionally followed agenda setting, and entails “finding, devising, and defining” solutions to the issues so identified (Howlett & Mukherjee, 2017, p.4). The development process may be further subdivided into various components, the first of which entails *appraisal* – that is, establishing the parameters of a policy issue, and collating information from which to devise potential responses (Craft, 2012).

Ideally, HIA would inform the initial appraisal stage such that each proposed policy alternative prospectively accounts for any potential negative health outcomes. To do so, six steps may be undertaken: 1) *Screening* entails a rapid review of available evidence to determine whether an HIA is needed; 2) *Scoping* requires planning the methods, content, and logistics of the HIA; 3) *Assessment* is the phase where the details of the scoping stage are carried out to identify the likelihood of health impact and their characteristics. Strategies to mitigate negative and enhance positive impacts are recommended according to political, social, and technical feasibility; 4) *Reporting* entails disseminating results to stakeholders; 5) *Monitoring* ensures that health predictions and mitigation strategies are valid and effective following adoption; and 6) *Evaluation* involves assessing HIA itself for future improvement (McCallum et al., 2015).

2.2 The Rationalist Assumptions of Evidence-Based Policy

Both HIA and the Evidence-Based Policy (EBP) movement aim to increase the scope of evidence that directly informs policy, with the expectation that “enhancing the information basis of policy decisions will improve results flowing from their implementation” (Howlett, 2009, p.157). HIA in particular entails efforts to integrate health information into the policy development processes of non-health sectors, wherein ‘health’ issues may be considered peripheral to established priorities, if at all relevant. This suggests that HIA is to some degree premised on the same rationalist assumptions underscoring EBP (Feyaerts et al., 2017).

According to the rationalist model, policy development is akin to applied problem solving, where an issue is identified, and a clear policy solution achieved through the most efficient means possible (French, 2018). To do so, ‘better’ empirical evidence introduced at the proposal stage results in more ‘rational’ policy outputs (Feyaerts et al., 2017). In similar fashion, WHO (1999) identifies the *ethical use of evidence* as a core value of HIA, where “every assessment should be based on the best qualitative and quantitative evidence available” (p.1).

However, rationalist assumptions are said to overlook the value judgments, sociopolitical contexts, and ideologies considered integral to policy-related decisions (Fafard & Hoffman, 2020). Moreover, that which constitutes ‘evidence’ in policymaking more realistically falls along a spectrum of input *types* and *sources* (Parkhurst, 2016), including public opinion, cost/benefit analyses, constituent and stakeholder input, partisan advice, internal data, and personal experience (Sohn, 2018). This range highlights the pluralist nature of policy advisory systems wherein myriad vested interests, both internal and external to government, compete to define the “contours” of an issue (Workman et al., 2009). In addition, when institutional arrangements privilege certain information, resulting ‘policy monopolies’ may limit debate and reinforce status quo solutions (Cairney, 2012). Finally, rather than stemming from a sole authority, policy decisions typically diffuse across institutional hierarchies and policy networks. Consequently, the

same evidence may be subject to different interpretations among policy actors (Fafard & Hoffman, 2020). Taken together, these ‘realities’ of policymaking are said to highlight the ‘illusions’ of rational policy analysis: linearity, objectivity, unitary decision-making, sole ownership of expert knowledge, and analytical closure (Feyaerts et al., 2017; Hertin et al., 2009).

Situating HIA against its rationalist counterpart, and in recognition of the above-mentioned confounds is, therefore, a useful and necessary step in exploring its uptake.

2.3 A ‘Bounded’ Alternative

Bounded Rationality posits that cognitive, environmental, and emotional factors *constrain* comprehensive rationality. According to the comprehensive approach, policy actors are utility maximizers capable of considering all possible choice alternatives and their respective consequences (Smith & Larimer, 2017). In doing so, all information needed to link means to desired ends is available to, and systematically processed by, the decision maker (Jones et al., 2006). In contrast, Bounded Rationality is premised on a comparison of the absolute capacities of policy actors against the complexity of their policy tasks (Bendor, 2010). Individuals therefore rely on various heuristics to make decisions *fully intended* as rational (Smith & Larimer, 2017).

Whereas proponents of Bounded Rationality as a problem-solving approach argue that actors do reasonably well in undertaking complex tasks, others emphasize the detrimental impacts of functional and computational constraints (Bendor, 2010, p.163). Both camps appear pertinent in light of the inherent ‘boundary-spanning’ nature of the SDoH. For example, as a fundamental component of government bureaucracies, the division of labour permits the *serial* processing of environmental signals according to distinct policy jurisdictions (Workman et al., 2009). As such, each government unit may attend to a ‘partial representation’ of a complex policy problem (Daviter, 2015). In terms of intra-departmental policy objectives, the benefits of doing so, including enhanced efficiency and accountability, may reduce receptivity to more cross-cutting policy development (Peters, 2015; Smith & Katikireddi, 2013). Beyond specific sectors, the division of labour

is argued to economize on limited capacities by facilitating *parallel* processing (Workman et al., 2009). Accordingly, while governments may approximate comprehensive rationality, underlying fragmentation may impede the development of inherently intersectoral preventative strategies (Bendor 2010; Mulgan, 2008).

2.4 Policy Advisors as Decision Makers

Scharpf (1991) explains, “the ‘we identity’ functions as the collective referent for the development and evaluation of policy options” (p.57). Wildavsky’s (1979) ‘*truth to power*’ model is a popular conceptualization of the ‘we identity’ construct, according to which policy advice flows bilaterally from public servants to elected officials (Craft, 2012). Whereas Wildavsky identifies public servants as the sole source of policy advice, focus has since shifted toward the earlier-discussed ‘sharing of influence’ approach emphasizing the plurality of advisory systems (Howlett, 2019). It is therefore useful to discern the ‘we identities’ of various advisory sources according to their proximity to decision-making officials and, as such, their roles in shaping the contours of policy issues (Craft, 2012).

Professional public servants in advisory roles may contribute significantly to defining policy problems, developing possible solutions, and identifying policy goals (Nekola & Kohoutek, 2017; Page & Jenkins, 2005). They are therefore critical to establishing the *parameters of choice* for elected officials (Workman et al., 2009). In this regard, advisory systems have been likened to a “market for policy ideas and information” in which three ‘we identities’ may be discerned: 1) *knowledge producers* include information sources both internal and external to government; 2) *knowledge brokers* are intermediaries who collect, collate and repackage information into useable forms; and 3) *proximate decision makers* are the ‘consumers’ of said information (Howlett & Wellstead, 2010, p.3). The roles of policy advisors are largely understood to coincide with the knowledge broker position (Nekola & Kohoutek, 2017).

In Canada, the three most frequently cited responsibilities of sub-national policy advisors are notably *information* based, including the provision of advice, research and analysis,

and preparation of briefing notes and position papers (Howlett & Newman, 2010). While non-partisan advisors do not hold formal decision-making authority, they must decide on the *types* and *sources* of information to be brokered to political officials. Understanding of this day-to-day undertaking is critically lacking at the sub-national level (Howlett, 2019; McArthur, 2007).

2.5 Problem and Research Objectives

Canada's 13 provincial and territorial governments have significant policy and legislative authority over key determinants of health beyond the traditional healthcare realm, including education (Howlett & Newman, 2010). While HIA has gained a degree of international prominence over the last 15 years, Québec remains the only Canadian province to have implemented its use (Linzone et al., 2018). The present research therefore stemmed from the basic question of, *why do some governments but not others adopt HIA?*

The present study was designed in light of an increasingly widespread commentary regarding the need for interdisciplinary policy research (e.g., Greer et al., 2017) and, relatedly, an enhanced practical understanding of policymaking among academics, public health professionals, and health promoters (e.g., Sà & Hamlin, 2015; Zardo et al., 2014). As efforts to introduce HIA entail some degree of reform to existing processes and structures, it would arguably benefit HIA proponents to better understand *how* intra-ministerial policy development occurs, and *why* it occurs as such (Cairney, 2016; Fox, 2006).

This study therefore sought to open the 'black box' of policy development within a 'non-health' ministry of the Ontario government whose policy purview clearly aligns with the SDoH. Given the centrality of *information* to both public policy and HIA, the judgments and decisions that have traditionally guided purposive information seeking to support evidence-informed policy were of particular interest. Accordingly, this study explored perceptions of the rules, norms and values that shape decisions among ministerial staff who, as 'information brokers', possess notable capacity to set the parameters of policy

problems and their feasible solutions (Nekola & Kohoutek, 2017). The aim of this study was to expound the nuances of policy development in a ‘real life’ context. In so doing, the possible barriers to and facilitators of HIA adoption were also explored. Two research questions were addressed:

1. How and to what extent do individual-and organization-level determinants interact to shape purposive information seeking to inform intra-ministerial policy development?
2. What structures, processes or mechanisms are in place to enable or impede HIA implementation at the provincial level?

2.6 Literature Review

Information seeking is to some degree contingent upon individual-and organization-level factors within distinct government contexts. Nevertheless, there appear to be commonalities across geographical regions and levels of government. Perhaps most notably, information seeking is often *ad hoc* in nature, and policy actors are unable to systematically appraise the quality of information collected (Haynes et al., 2012; Naude et al., 2015; O’Donoghue Jenkins et al., 2016; Tait, 2016). Existing literature thus highlights the ‘iterative’ nature of policymaking in general (e.g., Naude et al., 2015) and the ‘messiness’ of information seeking to inform policy, more specifically (e.g., Berryman, 2006; 2008; Greyson et al., 2011; Haynes et al., 2012). Individual and organizational factors both facilitate and impede information seeking in light of these policymaking ‘realities’.

Information Seeking Motivations. Policy actors engage in purposive information seeking for various reasons. While such motivations are not usually a primary focus of this body of research, information seeking is often undertaken to support preferred policy directions (Greyson et al., 2011; Haynes et al., 2012). For example, O’Donoghue Jenkins and colleagues (2016) concluded that their sample of policymakers only found systematic reviews to be useful “when they had been commissioned to support policy decisions that had already been made” (p.6). Similarly, Tait (2016) noted that

policymakers often sought online sources that conformed to their own worldviews. Others found information seeking to be motivated by a need for factual information (Berryman, 2008; Tait, 2016), for policymakers to improve their understandings of unfamiliar issues or policy domains (Berryman, 2008), to anticipate reactions to proposed solutions (Berryman, 2006), and to avoid negative public or media attention (Greyson et al., 2011).

Information Sought. The information seeking literature remains markedly focused on academic researchers and peer-reviewed literature as key sources of evidence to inform policy development. It is perhaps for this reason that both are deemed widely sought among policy actors (Berryman, 2008; Doberstein, 2017a, 2017b; Naude et al., 2015; O’Donoghue Jenkins et al., 2016; Ritter, 2009; Tait, 2016). In this regard, there appears to be a preference for existing rather than commissioned research, largely due to time constraints. For example, the earlier mentioned utility of systematic reviews highlighted by O’Donoghue Jenkins and colleagues was attributed to both their time-saving potential and perceived credibility.

Despite the apparent popularity of academic-oriented sources, the literature does highlight a range of preferred information resources among policy actors. For example, Greyson et al., (2011) highlight policymakers’ preferences for in-house library researchers and information staff when undertaking ‘deeper’ interdisciplinary searches, whereas Tait (2016) similarly identifies the use of in-house statisticians and librarians to support major legislative or policy objectives (see also, Berryman, 2008; Ritter, 2009). The internet is also widely used to access evidentiary information (Berryman, 2008), trusted organizations and online publications (Greyson et al., 2011), and specialist websites (Ritter, 2009). Other commonly cited information sources include experts both within and beyond academia (Greyson et al., 2011; Naude et al., 2015; O’Donoghue Jenkins et al., 2016; Ritter, 2009), think tanks and advocacy groups (Doberstein 2017a; 2017b; Head et al., 2014), and news media (Head et al., 2014; Tait, 2016).

Policymakers also search interjurisdictionally to acquire different types of information and fulfill various policy-related tasks. For example, Haynes et al. (2012) note that civil

servants often identify new researchers via policymakers external to their own departments, whereas Naude et al. (2015) found that policy staff in South Africa consult inter-provincially and at the national government level. Others typically explore how policies of interest have been designed and implemented across geographic regions (Berryman, 2008; Greyson et al., 2011; Ritter, 2009). O'Donoghue Jenkins et al. (2016) note that other jurisdictions are often presumed to have better resources and evidence-seeking capacities.

Finally, policy actors are reported to rely heavily on formal and informal networks both within and beyond their respective policymaking contexts and, in some instances, input from colleagues is valued above all other information sources (Head et al., 2014). Elsewhere, staff and supervisors are said to function as feedback mechanism and sounding boards that help to define policy problems, shape subsequent information seeking strategies, and iteratively develop and refine possible solutions (Berryman, 2006; O'Donoghue Jenkins et al., 2016). Immersion within the organizational context, professional knowledge, and ease of access each add to the perceived value of such networks (Greyson et al., 2011; Tait, 2016).

Selection Criteria. There is a general sense that policymakers are regularly inundated with various types and sources of information (e.g., Doberstein, 2017; Greyson et al., 2011; Ritter, 2009). Berryman (2008) notes that the diversity of views surrounding policy problems and their feasible solutions poses a significant challenge to policy actors. Elsewhere, however, there is strong evidence that said actors employ distinct criteria to aid information seeking and source selection. For example, through two randomized control trials, Doberstein (2017a; 2017b) identified the use of a *credibility heuristic* (i.e., 'source effect') among policymakers, who filtered information according to perceptions of status, authority, and expertise. In so doing, policymaker participants privileged academic rather than think tank and advocacy-based research "based on an assumption of more rigorous standards and independence of scholarly work" (p.397) (see also, Ritter, 2009). In similar fashion, Haynes and colleagues identified nine criteria contributing to the perceived *trustworthiness* of information among civil servants and politicians. For

example, both groups preferred to consult with researchers who had a “realistic” understanding of government policy development, including bureaucratic and parliamentary processes (see also, Naude et al., 2015). The reputation of both researchers and their organization was also critical to their perceived trustworthiness (see also, O’Donoghue Jenkins et al., 2016), in addition to their authenticity, breadth of knowledge, collaborative and communicative skills, independence, objectivity, and pragmatism (Haynes et al., 2012). The authors note that perceived trustworthiness leads policymakers to utilize “tried and tested” (p.6) information sources, and rely on colleagues to recommend new researchers as a means of informal risk assessment. In similar fashion, Tait (2016) concluded civil servants to be “generally conservative” (p.95) in selecting information sources, with perceived *reliability* as the critical deciding factor.

The literature reviewed paid little attention to possible differences in decision criteria according to policymaker role. As a notable exception, while Haynes et al. (2012) identified congruence between civil servants and their political counterparts when selecting researchers with whom to consult, these groups assigned different weights to certain deciding factors. For example, whereas politicians gave greater precedence to the public perception and academic credentials of researchers, civil servants prioritized “the policy-relevance of their track record” (p.4). Similarly, Doberstein (2017a) notes the significance of the aforementioned ‘credibility heuristic’ observed among bureaucrats, as this group of policy actors “remain the critical gatekeepers of policy research and analysis in their role in briefing senior bureaucratic and elected leadership in government” (p.398). Finally, Greyson et al. (2011) highlight an “unspoken hierarchy” wherein policy actors who are “informationally privileged” (p.24) may view evidence-informed policymaking in a more positive light due to its demonstrated value and feasibility.

Search Closure. Despite the widely cited ‘information overload’ faced by policymakers (e.g., Doberstein, 2017; Greyson et al., 2011; Ritter, 2009), attention to ‘stopping rules’ is relatively scarce. Berryman (2006) observed that the ability to judge that ‘enough’ information has been collected depends in part on an initial cognitive framework, central

to which is a clearly defined policy problem. Both Berryman (2006; 2008) and Greyson et al. (2011) found that policy tasks, including problem definitions and objectives, are often unclear and unstructured at the outset of information seeking. An initial framework thus serves to guide subsequent information retrieval and, further, the assessment to stop this process. This latter component is said to be heavily informed by feedback from colleagues and supervisors, who contribute to an iterative process of developing and refining proposed solutions, including “whether or not the final versions [of a proposal] are sufficient” (p.4). Here, aggregated approval processes inherent to bureaucratic hierarchies also function to guide information seeking and stopping behaviour (see also Naude et al. 2015). Additional input from clients and stakeholders shape problem definitions and information requirements, and help policymakers to anticipate responses to their proposals. The decision to actually cease information retrieval is largely driven by time constraints (Berryman, 2006; Greyson et al., 2011; O’Donoghue Jenkins et al., 2016; Tait, 2016), as policy actors must typically accept information that is “good enough” rather than “optimal” (Berryman, 2008).

Information Seeking Barriers. Government policymakers face a number of common barriers to information seeking. Those most cited across the literature reviewed included time limitations (Greyson et al., 2011; Head et al., 2014; Naude et al., 2015; O’Donoghue Jenkins et al., 2016; Ritter, 2009; Tait, 2016); lack of support (e.g., training, resources) for information seeking tasks (Greyson et al., 2011; Head et al., 2014; Ritter, 2009; Tait, 2016); lack of skill or capacity to appraise information sources (e.g., reliability, bias) or make use of available information (e.g., inaccessibility of academic jargon) (O’Donoghue Jenkins et al., 2016; Naude et al., 2015; Tait, 2016); perceptions of ‘two communities’ between academic researchers and policymakers (Greyson et al., 2011; Haynes et al., 2012; Naude et al., 2015); poor applicability of available information (e.g., translation of findings to local context) (Naude et al., 2015; O’Donoghue Jenkins et al., 2016; Ritter, 2009); and reliance on the same resources, jurisdictions, or existing practices (e.g., ‘fear of innovation’) (Haynes et al., 2012; Ritter, 2009; Tait, 2016).

Information Seeking Facilitators. Convenience (i.e., ease of access) is the most frequently cited facilitator or information seeking and retrieval among government policymakers (Naude et al., 2015; O’Donoghue Jenkins et al., 2016; Ritter, 2009; Tait, 2016). This feedback is largely aligned with the above cited time limitations as a critical factor shaping government operations. Study participants often felt that enhancing the connections between policymakers and researchers (e.g., relationship building) would improve their ability to find and retrieve academic resources (O’Donoghue Jenkins et al., 2016; Tait, 2016). On the other hand, researchers should enhance their own understandings of the complexities of policymaking in order to “enable researchers and policymakers to jointly think of and frame research-and policy-relevant questions” (Naude et al., 2015, p.8). Staff networks have additionally been identified as a key means of locating certain sources of information (e.g., researchers, other policymakers) and research training and in-house library services may enhance the research capacity of policy actors who are not subject matter experts (Greyson et al., 2011; Naude et al., 2015; Tait, 2016).

2.7 Integrated Theoretical Approach

Understanding organization-specific phenomena requires an approach that “cuts across levels and seeks to understand a combination of perspectives” (Christensen et al., 2012, p.369). **The present study sought to explore the ways policy actor perceptions and understandings (i.e., individual or *micro-level* phenomena) interact with Ministry-specific rules, norms, and values (i.e., organizational or *meso-level* phenomena) to shape information seeking.** This multi-level exploration was guided by an integrated framework informed by the core tenets of *Bounded Rationality* (Simon, 1997) and *Normative Institutionalism* (March & Olsen, 1989).

2.7.1 Bounded Rationality: Policy Actor Perceptions and Understandings

Simon (1997) introduced Bounded Rationality as a theoretical challenge to the strict economic assumptions underscoring its predominant counterpart, Comprehensive

Rationality. This latter approach overlooks the inherent complexities of policymaking and, as such, gives primacy to the *outcomes* rather than *processes* of decision behaviour.

Bounded Rationality focuses on how decisions are shaped by a task environment, including too much or too little information (e.g., the availability of, or preference for, evidence); attention allocation (e.g., the use of decision-making heuristics); resource availability (e.g., limited time or budgets); and emotion. Bounded Rationality is premised on four principles (Jones 2003): 1) *Intended Rationality*: goal-oriented actors behave as rationally as possible. Thus, bounded rationality does not equate to *irrationality* or pertain to intelligence levels; 2) *Adaptation*: actors rely on heuristics such as cross-cutting environmental cues and framing which, over time, increasingly approximate the nature of the task environment; 3) *Uncertainty*: comprehensive rationality is unattainable due to the inherent uncertainty that permeates decision-making processes; 4) *Trade Offs*: the inability to conduct comprehensive information searches causes policy actors make decisions that are “good enough” rather than completely optimal. Simon (1961) deemed this phenomenon *satisficing* – that is, decisions which both satisfy and suffice.

2.7.2 Normative Institutionalism: Formal and Informal Norms, Values and Routines

March and Olsen’s (1989) Normative Institutionalism pertains to the ways in which formal and informal institutions *constrain* policy actor behaviour. “Institutions” include norms, rules, and routines “embedded in structures of meaning and resources that are relatively invariant in the face of turnover, and resilient to changing external circumstances” (March & Olsen, 2008, p.1). Institutions are therefore conceptually distinct from *organizations*. Examples of formal institutions include bureaucracies or legislative frameworks, whereas informal institutions may involve tacit knowledge or actor networks.

Central to Normative Institutionalism is a *logic of appropriateness* that guides boundedly rational actors. “Appropriate” behaviour depends on the organization in which training and socialization occurs (Olsen, 1991). Actor conduct thus stems from four key

considerations: 1) *What kind of situation is this?* Environmental and contextual signals are interpreted through combinations of complex reasoning, formal and tacit knowledge, and past experience. 2) *Who am I?* Depending on their professional role, individuals determine the duties and obligations that constitute appropriate behaviour within a defined situation; 3) *How appropriate are different actions for me in this situation?* Rules encode the appropriate action to be taken once a situation is defined and matched to professional obligation. While formal rules are enforced by organizational authorities, informal rules may be internalized, and “built into the structures themselves through socialization” (Peters, 2012, p.38); and 4) *Do what is most appropriate.*

2.8 Methodology

Case studies permit in-depth investigation of the *how* and *why* of contemporary phenomena (Yin, 2009). This methodology is particularly suitable for research seeking to better understand a specific process (Merriam, 1998). The present study sought to explore purposive information seeking (i.e., the *how*) as a partial product of micro-and meso-level interactions (i.e., the *why*). A single holistic case study design was employed to permit “exploration from multiple perspectives of the complexity and uniqueness of a particular event, institutions... or system in a ‘real life’ context” (Simons, 2009, p.21).

As contextual conditions are highly pertinent to the case study methodology, the unit of analysis (i.e., *case*) was bound in scope in the following ways: by *phenomenon*: policy development as a *process* of “seeking to identify the range of possible responses to a given definition of the problem” (Fafard, 2008, p.10). Of particular interest was *information seeking* as “the purposive acquisition of information from selected carriers” (Johnson, 1997, p.26, as cited in Case, 2007, p.80); by *setting*: Ontario’s Ministry of Education; by *timeframe*: a 15-year period between 2003-2018; and by *participants*: senior-level public servants as policy staff directly involved with policy development ‘on the ground’ and within ‘real life’ political settings.

2.9 Participant Eligibility and Sampling

Purposive sampling was used as a method of non-random selection based on the qualities of the candidate participants (Tongco, 2007). Individuals were eligible for participation if they were: 1) employed as a senior-level public servant within the Ministry of Education between 2003-2018 (i.e., ‘currently’ or ‘formerly’ employed at the time of recruitment); 2) employed for at least one year at the time of recruitment; and 3) fluent English speakers.

2.9.1 Participant Recruitment and Sample

Prospective participants deemed eligible for participation were contacted via their publicly accessible email addresses in April 2019. A total of 45 individuals were provided with a scripted study invitation, Letter of Information, and consent form (Appendix A). One follow-up email was sent to those who did not respond within two weeks of initial contact. Participants signed and returned the consent form and indicated their preferred date and time for a phone interview.

Nine participants were recruited between April and June 2019, including five Senior Policy Advisors, one Senior Policy Analyst, two Assistant Deputy Ministers, and one Deputy Minister. Six participants were actively employed with the Ministry of Education at the time of their interviews, whereas three were former employees. The average employment duration was approximately seven years, with two employed for more than 10 years, four between five and 10 years, and three fewer than five years. Four participants had worked as policy staff in more than one division or branch of the Ministry of Education.

2.10 Data Collection

2.10.1 Semi-Structured Interviews

Interviews were conducted using one semi-structured interview guide (Appendix B). The questions were asked in a predetermined and consistent manner while at the same time permitting a degree of flexibility for additional conversation (Berg, 2007). Each question

aligned with at least one of the four respective tenets of either Bounded Rationality or Normative Institutionalism. Given the complementary nature of these theories, a number of the questions aligned with both. The interviews therefore facilitated a ‘multi-level’ exploration of policy development within the Ministry of Education.

Telephone interviews were conducted between April and August 2019, and ranged from 45 minutes to two hours in length. Each was audio-recorded and supplemented with hand-written notes detailing resources for follow up, and additional questions based on the conversation taking place. Interviews were transcribed verbatim using Microsoft Word 2020, and accuracy ensured by listening to respective audio recordings during the initial coding process.

2.10.2 Policy and Process Documents

Insights into the contexts and factors shaping policy development were additionally sought through various documents (N=113). As policy development may be shaped by institutions beyond the organization of direct interest, resources at the Ministry, Ontario Public Service (OPS) and government levels were collected to: 1) supplement and corroborate respondent accounts of the contexts and factors shaping policy development between 2003-2018; 2) trace the 15-year evolution of the Ministry’s policy purview by detailing key priorities and programs; and 3) establish the Ministry’s historical approach to health promotion and protection.

The search process was guided by what respondents perceived as significant policies, legislation, and resources for policy actor conduct. Documents were retrieved via Google or the Ontario government website, and broadly categorized as *Government Resources* (n=39) and *Ministry Resources* (n=26). Data were also retrieved via the government’s *Newsroom Releases* webpage through which policy-related documents (e.g., backgrounders, press briefs) are routinely posted. A total of 263 archived pages were screened for resources that could further inform the above three study objectives. Thirty-eight publications were included as *Government Resources*. Finally, 10 instructional documents (e.g., policy standards, professional development guidelines) were retrieved

from the *Policy Innovation Hub* – an in-house consulting branch of Ontario’s Cabinet Office. These were categorized as *OPS Resources* since they are intended for internal use. Select documents were obtained through correspondence with the branch Manager.

2.11 Data Management and Analysis

Data were uploaded to NVivo 12 qualitative software for ‘theoretical’ thematic analysis (Braun & Clarke, 2006) guided by the integrated framework. Accordingly, the interview questions, all of which aligned with a core tenet of one or both theories, were established as an initial coding structure. Data were then organized, and themes identified according to “some level of patterned response or meaning” (p.82).

Whereas interview questions were useful in organizing the data based on their *semantic* (i.e., surface) qualities, *latent* analysis was undertaken to capture the nuances of corresponding data. This approach entailed a degree of interpretation in order to “identify underlying ideas, assumptions and conceptualizations that are theorized as shaping or informing the semantic data” (Braun & Clarke, 2006, p.84). The initial coding structure, and the core tenets of its underlying theoretical lenses as they unfolded ‘in practice’ were thus confirmed, refined or expanded upon through inductive analysis (Hsieh & Shannon, 2007). Descriptive codes were subsequently aggregated into higher-level categories and explored for possible relationships both within and between recurrent themes. The aim of this second phase was to establish a comprehensive understanding of the *how* and *why* of policy development within the Ministry of Education.

The thematic analyses of completed interviews and documentary data were conducted simultaneously. While this approach did not result in significant modifications to the interview questions, it did help to refine some of their respective prompts (e.g., to better facilitate conversation by providing specific examples of Ministry policy initiatives). Several steps were taken to ensure the *trustworthiness* of the present study (Appendix C).

2.12 Ethics

Data collection commenced following approval from the Western University Non-Medical Research Ethics Board (NMREB) (ID: 113692) (Appendix D). To ensure anonymity and confidentiality, all personal identifiers were removed from the transcripts. Moreover, all transcripts and NVivo files were password protected, and all study documents stored on a secured private server.

2.13 Findings

2.13.1 Allocating Attention: The Policy Purview of the Ministry of Education

Ontario's Ministry of Education is responsible for allocating funding to regional school boards, ensuring compliance with the *Education Act* (1990), designing province-wide curricula, setting provincial standards for achievement, and developing and implementing policies related to elementary and secondary education (Lysyk, 2017). Since 2003, the Ministry has released three education policy frameworks detailing specific goals and objectives within this broader policy purview (see Appendix F). Such frameworks, often deemed *visions* for public education, permit the government of the day to communicate education-related values, both explicitly and implicitly, by giving precedence to select policy issues.

From an operational standpoint, this means of allocating attention increases the likelihood of delivering on the priorities so identified. As a former Senior Policy Advisor explained, “you have to think in a four-year window... Most [policy] work is done in years two and three” (E6). Similarly, a former Assistant Deputy Minister (ADM) highlighted the strategic benefits of a narrow ministerial focus: “There's so much thrown at you that you need to have your true North – what you really want to deliver. You need to pick three priorities and stick to them” (E7).

Ontario's public servants are expected to align their policy work with the goals and priorities of the elected government. To facilitate this, the OPS Quality Policy Standards

highlight a series of considerations for policy staff, such as *‘does your project’s critical path include steps to check consistency with government priorities and OPS directives?’* (Cabinet Office, 2013, p.13). These and similar reflections are relatively consistent with participant insights into policy development. However, their responses suggested more of a general awareness of the Ministry’s policy objectives rather than their incorporation into the development process as explicit considerations. As a current Senior Policy Analyst explained, “we sort of look at the core principles of the ministry... everything we do is at least somewhat within that parameter” (E8).

Other respondents emphasized the Ministry’s goals and objectives as markedly more central to policy development. This difference appeared to reflect a closer proximity to the ‘political side’ of the ministry. For example, a former staff member recalled the distinct role of the three overarching goals which guided Premier McGuinty’s decade-long education reform efforts (detailed in Appendix F): “you’re measuring next to these three goals. So, how does the policy raise the bar? How is it closing the gap? These overarching directions were a good way to justify, okay, how is this policy addressing the ministry’s three goals?” (E5). Similarly, another participant described these as drivers of routine activity within the Ministry of Education:

We had this one-pager where the ‘A list’ was, what needs to be moved forward to advance these three goals? The ‘B list’ were important topics to advance; The ‘C list’ were topics we weren’t going to spend a lot of time on; And then ‘distractors’ were any issue that someone needed to pay attention to so that they didn’t divert the agenda from the ‘A list’. (E7)

Thus, compared to those involved with policy development ‘on the ground’, public servants situated closer to the political side reported more routine and explicit consideration of the ministry’s overarching priorities. This difference appears to reflect government mandates established between 2003-2018 – most of which were addressed to elected officials. In 2009, for example, the McGuinty government amended the Education Act (1990) to specify “all partners in the education sector, including the Minister, the Ministry and the boards [of education] have a role to play in enhancing

student achievement, closing gaps in student achievement, and maintaining confidence in the province’s publicly funded education system” (*Education Act*, 1990, p.12).

Elsewhere, public servants are encouraged to reflect on government priorities, discuss evolving political directions, and engage in ongoing communication between central agencies and line ministries (Cabinet Office, 2013). As a current Senior Policy Analyst explained, however, formal communication across Ministries is typically limited to those in more authoritative positions: “the ADM has ministry-wide purview, but the DM would be in touch with other ministries” (E8). Thus, while policy staff are expected to operate within the purview of the Ministry of Education, the degree to which distinct overreaching priorities were perceived to shape the day-to-day of policy development depended on where participants were situated within the ministerial hierarchy. This appears to reflect key distinctions in the duties and expectations of policy actors within the OPS, which are reinforced by certain formal institutions – namely, the bureaucratic hierarchy.

2.13.2 Policy Staff Conduct: Structure, Norms & Values

A number of respondents understood their duties as senior policy staff to be determined by their positioning within the Ministry’s bureaucratic hierarchy. This is consistent with a number of expectations within the OPS Competency Refresh Dictionary. For example, *concern for image impact* states that senior employees should be aware of their own roles both in relation to others, and within the broader organizational context (e.g., their respective unit, branch, or division) (Cabinet Office, 2004a). Each professional role may be defined according to a corresponding range of ‘appropriate’ conduct. In this regard, all interview respondents defined their roles as public servants against the duties of political officials. As a current Senior Policy Advisor explained, “as a non-partisan bureaucrat, I provide advice to political personnel. Nothing will be implemented unless a Minister signs off. I can provide advice against doing something, but I’m not the decision maker” (E9). Similarly, a former DM stated:

Bottom line, the government was elected, and I wasn’t. And they’re going to move on whatever the public elected them on. So, I would always tell my

staff, our job is to make sure that all the policy options and their impacts are in front of them. (E5)

Policy staff are also expected to adhere to a series of organizational values that have remained relatively unchanged since at least 2003. Said values are intended to “guide behaviour and relationships” and, as such, are considered foundational to the OPS working environment (Government of Ontario, 2021a, p.1). Elsewhere, they are put forth as a set of ideals against which conduct should be measured (Cabinet Office, 2011). Participants generally reflected these values without referencing them explicitly. For example, public servants are to exhibit *impartiality* by providing ministers with objective advice while fulfilling “the decisions and policies of elected government” (Ministry of Government Services, 2011, p.3). Moreover, policy staff *excellence* entails providing “the best policy advice” to meet the needs of Ontarians. (p.4).

2.13.3 Defining Policy Problems and Objectives

The Policy and Delivery Roadmap provides policy staff with “a clear outline of how policy *should* be developed in Ontario” [Italics added] (Cabinet Office, 2011, p.1). However, the roadmap notes that policymaking is rarely a linear or straightforward process. As such, this resource is intended as a practical heuristic in that it presents the policy process as a cycle with distinct phases and feedback loops. For example, Phase 1 stipulates that both an *initial problem statement* and a *clear mandate* should be established at the outset of the policy process to ensure a consistent understanding of the ‘symptoms’ of a problem, ministerial objectives, and potential directions or solutions (Cabinet Office, 2011). The subsequent *validating* phase is described as a ‘milestone’ through which a shared understanding of the policy problem among staff and officials is established. From here, *defining objectives and outcomes* can be undertaken.

The above steps are consistent with expectations outlined in other OPS resources. For example, the Policy Process Standards indicate that by clearly defining the policy problem and related objectives, policy staff can ensure that the development process is *outcome focused*. To do so, they are encouraged to ask questions such as, “*what is the*

problem you're trying to solve?" and, *"do you understand the root cause of the problem?"* (Cabinet Office, 2013, p.5).

The inherent 'messiness' underscoring the above steps and expectations was highlighted by participants. For example, a former ADM described the development of policy options to entail more of an iterative rather than linear process: "very often policymaking is the Minister's office coming to you saying, 'we want to do x'. And then it's, okay, understand the issue and come up with some options to kick start the early back-and-forth that's usually needed to really move forward" (E7). Moreover, in contrast to the roadmap approach through which policy problems are defined at the outset, a current Senior Policy Analyst explained, "often a solution is put forward, and we're often fond of saying, this is a policy solution in search of a problem to address" (E8). Similarly, rather than working with a shared understanding of clearly articulated policy objectives, some participants indicated a routine need to discern such details themselves. For example, a current Senior Policy Advisor noted, "I'm not sure that we always get the entire reason, but we do as much work as we can to figure out why we're asked to develop certain policies" (E4). Another current Senior Policy Advisor similarly explained, "it's not always clear why they want to do something, so there's a bit of reverse engineering required to get back to, what's the policy problem here?" (E2)

The above accounts are consistent with other indicators of 'effective functioning' among OPS staff. For example, senior-level employees are expected to engage in *information seeking*, described as "digging or pressing for exact information" (Cabinet Office, 2004a, p.13). They are also encouraged to *personally investigate* problems and solutions by questioning people closest to the issue. Policy staff may therefore play a critical role in *validating* (i.e., establishing a shared understanding of) policy problems, objectives, and solutions through a process of iterative exchange both within and beyond the ministry. This suggests a notable discrepancy between the linearity of certain government policy guides and 'on the ground' policymaking, particularly with regards to when and how policy problems are established and communicated.

2.13.4 Routine Components of Government Policy Development

The OPS Policy and Delivery Roadmap defines policy development as the process of “generating a variety of broad solutions to a policy problem” (Cabinet Office, 2011, p.4). To do so, policy staff are advised to explicitly consider what each potential option must contain to achieve the policy goals and objectives established during earlier phases.

Participants were generally reluctant to speak definitively to a routine approach to policy development, noting instead that the ministry-level is too broad to identify any consistent or shared processes. As a current ADM explained, “you really just can’t have checklists. This place is so unbelievably complicated. From financing, to daycare policy, to special education... In every instance there’s different sets of eyes on what we’re doing” (E1). Similar reluctance was extended to policy development at the division, branch, and unit levels. As a current Senior Policy Advisor explained, “policy is very theoretical. It’s almost like anything goes” (E2). Similarly, a current Senior Policy Analyst noted, “eventually you’ve got to force everything to jive together, but you’re not quite on a smooth path, you’re on quite an angulating path to get where you need to be” (E8). In this regard, participants generally agreed that policy development is highly contingent on a range of factors and circumstances both within and beyond the Ministry. Those consistently identified are detailed in Table 1.

Table 1: Contexts and Factors Shaping Policy Development Processes

Contexts & Factors	Participant Feedback
Issue Familiarity	<i>It depends on how well versed we are with the issue. If it’s something that we know a lot about then it will be a different effort because we’ve done a lot of the due diligence already. (E3)</i>
Time Constraints	<i>A large factor mostly has to do with time. If time is limited, then different pieces of the process either get skipped or collapsed. (E4)</i>
Cost	<i>We’d love to be able to do whatever we want, but there’s always a cost constraint. (E5)</i>

Political Agenda	<i>For a number of years education was the number one priority of government. The Premier was nicknamed the “Education Premier”. We had a very strong Ministry and, as a result, I think the [policy] process was somewhat simplified. There was a lot of latitude. (E7)</i>
Government Turnover	<i>When there’s a change in government, that does have an impact on the policy process. When the new party comes in, especially when it hasn’t been in power for a long time, it takes a while to sort out how they’re going to run things. (E4)</i>
Senior Management Style	<i>A friend was working for an ADM who was a control addict. Some of my friends aren’t even being given advice anymore. They’re asked for a statement about something they know nothing about, which is different than when I was working for people who would tell us the high strategic goal. I knew the purpose, and I knew the facts. (E6)</i>

The OPS identifies *flexibility* as a key competency through which senior policy staff “adapt to new or changing situations, requirements, or priorities” (Cabinet Office, 2004a, p.1). Flexibility appeared to be widely employed by interview participants, as their approach to policy development often depended on certain contexts and factors such as those describe above. Despite its contingent nature, however, *evidence, consultation and collaboration, policy referencing, and risk analysis* were identified as steps typically undertaken across a range of circumstances. These were described by many as ‘due diligence’ for policy development.

2.13.4.1 Routine Component 1: Evidence

OPS-and ministry-specific resources clearly indicate *evidence* to be a required component of policy development. The Policy and Delivery Roadmap in particular states, “sound policy is built on evidence, not assumptions, hearsay, or the desire of one or many stakeholders” (Cabinet Office, 2011, p.3). Accordingly, policy staff are instructed to use evidence to both test the assumptions underscoring a policy problem and inform the development of possible solutions. Similarly, the OPS Quality Policy Standards note, “when seeking information, it is tempting to consider only sources we are already familiar with and that agree with us. An evidence-based approach requires us to draw on

a range of perspectives and approaches to challenge initial assumptions” (Cabinet Office, 2013, p.6). To engage in “honest conversations”, policy staff are encouraged to: 1) define policy problems and develop possible solutions using the highest quality information, keeping in mind factors such as credibility, bias, relevance and context; 2) evaluate policy options against clear criteria; 3) explicitly consider the quality and strength of a range of perspectives; and 4) proactively address knowledge gaps (Cabinet Office, 2013). Finally, the Ministry of Education has in the past explicitly mandated an evidence-based approach to attain policy goals and objectives. For example, to support student transitions from childcare to postsecondary education, a 2017-18 mandate calls on policy actors to leverage information, data and research to “inform policies and make program decisions for quality services and outcomes” (Ministry of Education, 2017, p.3).

Evidence Retrieval. While participants generally agreed that “there is an expectation that policy is evidence-based” (E7), they also indicated that there is no standard approach to the retrieval process. As such, their feedback revealed a range of perceptions and experiences. For example, a former ADM (E7) depicted this process to entail generating branch-or unit-specific data, primarily through the Education Quality and Accountability Office (EQAO)¹ and standardized student testing. Alternatively, a current Senior Policy Advisor described retrieval as “mostly looking online to see what already exists... So, I would say fact finding, analysis, and then a synthesis of information to provide options to senior management” (E4)

Respondents also detailed experiences regarding venues for evidence retrieval and exchange. In particular, those closer to the ‘political side’ of the ministry tended to highlight international education delegations as key information resources. Between 2003-2010, Ontario hosted more than 435 of these delegations and, in 2012, the Ministry of Education stated it would continue this approach as a means of examining best

¹ The EQAO is an arm’s length government agency that “provides schools and school boards with detailed reports about their students’ achievement as well as contextual, attitudinal and behavioral data via interactive online reporting tools” (EQAO, 2020)

practices across jurisdictions (Government of Ontario, 2010a). The same respondents also consistently highlighted *The Council for Ministers of Education, Canada* (CMEC) – a national body established “to promote discussion of issues of common interest, as well as collaboration and consultation” (CMEC, 2001, p.15). A former DM explained, “we would frequently host guests, and that forced us to articulate our strategy and lessons learned, and then they would highlight their best practices for us to consider” (E5).

In contrast to this feedback, policy staff in less authoritative positions tended to reference ‘in-house’ options for evidence retrieval. These included the Ministry’s Education Statistics Analysis Branch, which collects and disseminates student-and teacher-level data to policy and program branches (Government of Ontario, 2021b); the Education Research and Evaluation Strategy Branch, which provides strategic direction for research and knowledge mobilization to inform evidence-based decision making (Government of Ontario, 2021c); and the Brian Fleming Research and Learning Library through which public servants have access to research staff, reports, and journal articles (Government of Ontario, 2021d).

In light of the range of experiences regarding evidence retrieval, jurisdictional scans were consistently identified as a key information source to inform policy. Although similar to the national and international evidence exchange venues highlighted by those closer to the political side, jurisdictional scans were routinely conducted by the majority of interview respondents. Accordingly, they were said to be useful in both “identifying any lessons to be learned” (E3) regarding policy success or failure experienced elsewhere, and “making sure the ministry isn’t an outlier” (E9) in terms of policy directions or solutions. To do so, some participants tended to explore similar strategies implemented by Federal and Municipal governments (E9), whereas others typically looked to geographic areas they considered comparable to Ontario. For example, one current Senior Policy Advisor explained, “we look at jurisdictions with a social or liberal democracy” (E3), while another noted, “we always search across Canada, the UK and Britain, and sometimes Australia. Anything else we don’t really have time for” (E4).

Evidence Uptake and Use. Similar to their accounts of evidence retrieval, respondents also expressed a range of perceptions and experiences regarding *where* evidence is typically incorporated into the policy development process. For example, a former ADM responded, “I would say that generally evidence was used proactively to inform decisions. I don’t really recall it being collected after the fact” (E7). On the other hand, a current Senior Policy Advisor explained, “it depends on the appetite. If a minister has something in mind and they don’t really care? They just ask us to move forward [laughs] I’m just being honest” (E3).

Similar to the contexts and circumstances shaping policy development broadly, respondents consistently identified *issue familiarity* and *time* as two key determinants of evidence retrieval and use. Specifically, new or innovative policy initiatives were understood to require more research and background work: “if we’re doing something that’s brand new, one of the ‘to-do’ items that you need to check off is that you’ve got the research” (E7). However, time limitations were said to often prevent systematic approaches: “sometimes you just don’t have the time to pour over research articles, so you just grab the top three that you keep hearing about” (E9).

2.13.4.2 Routine Component 2: Consultation and Collaboration

The OPS Quality Policy Standards describe policy development to be *engaged and horizontal* when it is deliberately informed by a range of perspectives from both within and beyond the OPS. These may come from individuals or groups anticipated to be directly impacted by a policy (e.g., school boards, parents), or from those with related knowledge or expertise (e.g., academics, other ministries). The standards further note that failure to engage “runs the risk that our understanding of the policy problem will be incomplete, and solutions ineffective” (Cabinet Office, 2013, p.11). Staff are therefore encouraged to ask questions such as, “*who else might be affected?*” and, “*have you outlined the costs and benefits to each stakeholder?*” (p.11). In doing so, the “best possible” outcome may be achieved within a given timeframe.

Consistent with the above policy standards, all interview participants identified consultation and collaboration as routine components of policy development. However, their experiences with these processes appeared to be determined by several factors. Many reiterated the different roles and responsibilities within the bureaucratic hierarchy, with those higher up generally deemed ‘gatekeepers’ of engagement. As a current Senior Policy Analyst noted, “there is often an engagement process, but that very much needs to be okayed from above” (E8). Similarly, a former DM explained, “we generally engaged stakeholders only after a proposal had been vetted by the Minister’s Office to go ahead with consultation” (E5).

Differences in respondent experiences also appeared to reflect key distinctions between ‘consultation’ and ‘collaboration’. Specifically, all indicated considerable experience with consultation, which referred to internal or external engagement to inform the development of *education-based* policies. However, notably fewer respondents had experience with collaboration, which was described as inter-ministerial partnerships to develop policies internal *or* external to the Ministry of Education. Those who had participated in such efforts tended to work closer to the ‘political side’, or within branches with shared mandates across ministries. Engagement therefore appeared to be contingent on where respondents were situated both within the ministry’s organizational structure, the hierarchies contained therein, and mandate overlap.

2.13.4.2.1 Consultation to Inform the Development of Education-Based Policies

Participants consistently identified key individuals and groups with whom policy staff have traditionally consulted. This feedback was notably aligned with formal expectations for policy staff conduct, as outlined in the OPS Competency Refresh Dictionary (see **Table 2**).

Stakeholder Engagement. All interview participants identified stakeholder engagement as a critical component of policy development. As such, education ‘stakeholders’ were described as those likely to be impacted by education-based policies, including unions,

teachers’ federations, principals’ associations, school boards, support staff, parent groups, and students.

A number of engagement methods were identified. For example, Ontario’s Regulatory Registry is an online platform through which the government posts proposed or approved regulatory changes. In doing so, relevant stakeholders may actively participate in developing new or improved regulations (Government of Ontario, 2020). For instance, in 2015 the Ministry of Education received nearly 1,300 submissions following a request for stakeholder input to inform amendments to the Child Care and Early Years Act (2014): “the ministry values the unique and diverse perspectives from parents, families and broader childcare, education, service system management and early years partners” (Government of Ontario, 2016a). Other noted channels for stakeholder engagement included recurring provincial consultations, standing committees, stakeholder interviews, and research conferences.

Table 2: Summary of Consultations to Inform the Development of Education-Based Policy

Expected Conduct	Respondent Feedback
Stakeholders	
<i>Partnership Building:</i> Form interest-based relationships; Collect diverse perspectives; Seek win/win outcomes. (p.10)	<i>There was an acute sensitivity around stakeholder engagement... So, if it was about, you know, we can just do what we want, we don't talk to the teachers' federation, we'll just railroad it? That was not an option. (E7)</i>
Expert Advisors	
<i>Information Seeking:</i> Ask probing questions; Consult with individuals or groups not directly involved with the policy initiative; Seek more than one answer. (p.13)	<i>Sometimes you have a policy that looks beautiful on paper, but then it's totally unimplementable. So, the experts really give us that reality check that you need. I lean on those people a lot because, you know, I have strong policy skills, but I've never taught in a school. I'm not an educator, right? So, I feel very lucky to have access to that expertise. (E3)</i>

Informal Networks	
<i>Networking:</i> Identify mutual interests and establish working relationships; Establish systems or habits to get information. (p.13)	<i>I'd say, 'let's meet for coffee', and we would each share what we knew, and then go back and influence without saying where we got the ideas. It's the unspoken expertise of a senior policy person – you have to know who you can talk to, and when, and how. (E6)</i>
Intra-Ministerial Staff	
<i>Integrated Development:</i> Consult with a range of institutional perspectives, including key business lines within the Ministry. (p.10)	<i>We've got policy development, and what's usually called a programs branch. We have a research unit, a financial analysis unit, and a pure policy branch. Then we have our [redacted] branch. It's a cross-divisional approach, and we're all in the room together. (E9)</i>

Expert Advisors. Respondents identified various types of consultations with different 'expert advisors', who were generally described as subject matter experts. For example, a current Senior Policy Advisor (E4) highlighted the government's *Safe School Action Team* which, upon its 2004 initiation, was comprised of safety and education experts, and headed by then-Parliamentary Assistant to the Minister of Education. Originally mandated to develop a comprehensive approach to school bullying prevention, the team was positioned *internally* to support the government's Safe School Strategy (Government of Ontario, 2008).

Others spoke of *external* advisors commissioned to inform the development of specific initiatives. For example, in 2007, Premier McGuinty appointed Dr. Charles Pascal as the government's Special Advisor on Early Learning. As an expert in applied psychology and human development, Dr. Pascal designed an implementation plan for the province's proposed full-day kindergarten program (Government of Ontario, 2007). Accordingly, the majority of recommendations put forth in the 'Pascal Report' (2009) informed the initiative's phased introduction in 2010.

Informal Networks. Some interview respondents indicated their ‘informal’ networks to include former colleagues both within and beyond the Ministry of Education. These networks were established naturally as policy staff worked together within shared organizational contexts. Others described intentional efforts to cultivate ‘behind the scenes’ working relationships with staff outside of their own work settings. In both cases, informal networks were considered to be highly valuable, as they provide additional perspectives and information to inform policy development, or advanced notice regarding potentially relevant policy decisions made elsewhere. As a former Senior Policy Advisor explained, “it used to be called the ‘watercooler’, only this isn’t for gossip. It’s the watercooler of information” (E6). The OPS Quality Policy Standards deem this as one approach to ‘integrated’ policy in that “the project team educates itself about related initiatives being led in other divisions or ministries” (Cabinet Office, 2003, p.10).

Intra-Ministerial Consultation. Formal engagement within the Ministry of Education was also reported as a required component of policy development. To ensure this process is integrated, staff are encouraged to ask questions such as, “*does the proposed policy initiative complement or conflict with other initiatives in your Ministry or the OPS?*” (Cabinet Office, 2013, p.10). Consistent with this sort of consideration, interview participants identified three types of intra-ministerial consultation. First, given their ministry-wide purview, ADMs often consult with those of other divisions to ensure all “necessary bases” (E7) are covered. Second, to gather additional insights or opinions on certain policy portfolios, senior policy staff noted they were often encouraged to engage more formally with other branches or units in the ministry. Finally, all respondents considered it “due diligence” to consult with central departments, including the Legal Services Branch (e.g., for legal support), Communications (e.g., for media relations), and Operations (e.g., for strategic planning).

2.13.4.2.2 Collaboration within the ‘Health Purview’ of the Ministry of Education

As the OPS Quality Policy Standards note, “policy options often have wider reaching impacts than may be visible at first glance” (Cabinet Office, 2013, p.10), policy staff are

instructed to collaborate with actors across all potentially relevant ministries to mitigate this ‘risk’. Accordingly, participants were asked to describe instances of collaborative policy development involving the Ministry of Health and Long-Term Care (MOHLTC) or other health actors such as public health units. While most indicated that they had not engaged with health stakeholders while working within the Ministry of Education, others identified two circumstances for this type of collaboration. The first was described as “parallel track” initiatives (E8), which have generally entailed shared policy or program responsibility between at least two ministries. The Ministry of Education in particular may or may not ‘own’ these portfolios, and the policy or program may or may not be implemented within childcare or school settings. A notable example of this sort of initiative is the province’s *Community Hubs* policy through which surplus public buildings (e.g., government buildings) are repurposed according to community needs (e.g., social service centres). In 2015, five ministries, including Education, were mandated to engage in ‘creative partnerships’ to fulfil this objective (Pitre, 2016).

The second type of collaboration was described by a current Senior Policy Advisor as centered on “direct health links” (H4). This has typically entailed a shared mandate to develop policies or programs within a *school-based health promotion* framework (detailed in Appendix G). While the Ministry of Education may or may not own these portfolios, they are implemented within childcare and school settings. For example, Phase 1 of the province’s comprehensive mental health strategy, *Open Minds, Healthy Minds* (2011), included three early identification and intervention initiatives to be implemented within secondary schools. Said initiatives were developed through inter-ministerial collaboration between the Ministries of Health, Education, and Child and Youth Services, with the latter serving as the portfolio lead (MOHLTC, 2011).

Respondents who had engaged in collaborative policy development to address “direct health links” were situated within more health-oriented areas of the Ministry of Education. This calls to attention the traditional organizational structure of government ministries, wherein broad policy mandates are typically established horizontally across divisions, and become increasingly granular at the branch and unit levels. As such, areas

of the Ministry of Education more proximal to explicit health issues have traditionally operated within a *health purview* defined by the Ontario Public Health Standards (OPHS) (MOHLTC, 2008; 2018) (previously the Mandatory Health Programs and Services Guidelines, 1997). Despite various iterations, the OPHS have typically required regional school boards to collaborate with corresponding boards of health to develop *school-based health promotion* initiatives to “promote the protective factors and address the risk factors” within institutional settings (MOHLTC, 2018, p.10). Between 2003-2018, a number of policies, programs and legislations were implemented to address a range of “direct health links”, including injury prevention, healthy eating, immunization, mental health promotion, and physical activity (see Appendix G). Accordingly, participant feedback generally tended to reflect this health purview. For example, a former ADM noted, “there may have been interactions with public health units, especially with lead in water, or black mold that forced the closure of portables... but to say that we were consulting with the [MOHLTC] in the articulation of our key goals and strategies? Not that I recall” (E7).

Respondents consistently identified *time constraints* as the most critical barrier to more widespread approaches to health stakeholder collaboration. As a former DM explained, “it’s not about being oblivious to health determinants, but one thing that I’ve learned is you’ve got to pick four or five things to work on in the limited time that you’ve got” (E5).

2.13.4.3 Routine Component 3: Policy Referencing

Participants generally agreed that existing policies (i.e., those already implemented by the Ontario government) tend to serve as foundations or reference points for the development of new initiatives. A current Senior Policy Analyst explained, “in my experience, everything has kind of bled from what has previously existed, and been developed upon, but hasn’t parted dramatically from it” (E8). In this regard, a number of respondents stressed that policy referencing should be viewed as an evolutionary process: “policy doesn’t really have a start and end date. Really, it’s an evolution of the previous policy, so it’s always kind of iterative” (E7).

The evolutionary nature of policy is clearly illustrated by the education frameworks released by Ontario's successive Liberal governments. For example, at the outset of its reform efforts, the McGuinty government's *Vision for Excellence in Public Education* (2004) established three high-level goals to guide the Ministry's policy focus, including *improving student achievement, closing the gaps, and enhancing public confidence*. A decade later, the Wynne government released *Achieving Excellence: A Renewed Vision for Education in Ontario* (2014) with the explicit aim of "building on the gains made in education over the past 10 years" (Government of Ontario, 2014a, p.1). To do so, the Ministry of Education recommitted to the above three goals, while additionally focusing on *student wellbeing* as a fourth distinct priority. Policy and program initiatives within the 2014 framework were also modified to better align with the values and priorities of the government of the day. In 2015, for example, the ministry implemented the province's first updated elementary sex education curriculum in nearly 20 years. This initiative was said to better reflect "Ontario's growing and diverse population" while addressing "the health, safety and wellbeing realities faced by today's students, including online safety" (Government of Ontario, 2015, p.1)

As a routine component of policy development, policy referencing is consistent with the stated expectation that senior-level policy staff "utilize previously acquired knowledge as it applies to current situations" (Cabinet Office, 2003, p.4). In this regard, participants generally highlighted the value of policy referencing as a means of *providing continuity, guiding improvement efforts, and providing a 'baseline' for implementation and monitoring*. Drawbacks were consistently reported to include *lack of innovation* and building upon *outdated or problematic policies*.

2.13.4.4 Routine Component 4: Risk Analysis

The OPS Guide to Public Service and Ethics Conduct defines *risk* as "the chance of something happening that will impact on the achievement of objectives" (Ministry of Government Services, 2011, p.6). With uncertainty identified as an inherent 'reality' of policy development, the guide acknowledges, "all required facts to make a decision may not be available or cannot be obtained without inordinate expenditure of time or expense"

(p.13). Accordingly, risk management requires that policy staff identify, assess, act upon and monitor the “*best possible*” action under uncertain conditions.

Risk analysis was identified as a routine strategy to prevent or mitigate potential ‘risk’ surrounding education policies, generally described by participants to involve negative stakeholder responses to, or public perceptions of, proposed initiatives. Financial impact was also commonly highlighted as a key risk priority. These considerations have typically been incorporated into decision notes to aid senior personnel in pursuing what they feel is the ‘*best possible*’ course of action. As a current Senior Policy Advisor explained, “when I say ‘risk analysis’, it’s not a scientific or in-depth presentation of data or research. Mostly it’s our own identification of whether risk is high, medium or low, and details for mitigation strategies” (E4).

The OPS states, “it is important to consider that individual ministries may have unique and distinctive ways of naming, processing and using notes” (Ministry of Government Services, n.d., p.2). As such, there is no standardized approach to the development (i.e., format or requirements) of decision notes within or across ministries. This detail was noted by some respondents. For example, a current Senior Policy Advisor explained, “some Directors and Ministers are pretty easy going in terms of templates, while others are more rigid. I think we currently have to do a stakeholder analysis, and a financial and general risk analysis. So, they one hundred per cent change all the time” (E9).

2.13.5 Moving Forward: The “End” of Policy Development

By the end of the policy proposal stage, staff should be able to present officials with evidence-based recommendations (Cabinet Office, 2011). In light of the above routine components of policy development, respondents were asked when ‘due diligence’ surrounding evidence retrieval, consultation and collaboration, policy referencing, and risk analysis is considered complete or sufficiently fulfilled. While most agreed there is typically some uncertainty surrounding this decision, their responses suggested a degree of pragmatism. For example, a current Senior Policy Analyst explained, “within the

policy world you're under significant time pressure to figure out what it is that you need. So, the term 'good enough' comes up a lot" (E8).

Given the uncertainty underscoring policy development, staff are instructed to brief senior officials on a regular basis to reveal gaps in messaging, and to facilitate informed decision making (Cabinet Office, 2013). Consistent with this advice, a number of respondents spoke of standard 'checks and balances' to ensure that, to the extent possible, all potentially relevant considerations are accounted for. This feedback further reiterated the operational utility of both the organizational structure of government ministries (i.e., the horizontal and vertical allocation of attention) and the clearly defined hierarchies therein. For example, a current Senior Policy Analyst explained, "If I'm passing something up to my manager and it's not what's needed, then it's only going one level. As the ultimate decisionmaker, the Minister usually sees what he or she hopes to see rather than the messy process beneath them" (E8). Similarly, a former Senior Policy Advisor noted, "our director's role would be to ensure not only quality control and fit for purpose, but they would also look across other branches and divisions to ask, do we need input from these folks?" (E6).

Finally, respondents noted that Cabinet, comprised of all Ministers of the governing party (i.e., the "Executive Council"), has traditionally functioned as a 'last stop' review and approval venue to inform policy decisions. This process is often centered around Cabinet Submissions² as "the main tool that government uses to evaluate options and recommendations to arrive at decisions on a policy issue" (Cabinet Office, 2004b, 6). Accordingly, the four routine components of policy development so identified by interview participants were notably aligned with the tool's core requirements. As a former DM explained, "you embed all of this information into the Cabinet Submission – what are you trying to achieve? What are other jurisdictions doing? What are the risks and how will you mitigate them? So, it's very templated" (E5).

² Cabinet Submissions are used to attain approval for initiatives that exceed the authority of a DM or Minister, such as those likely to have significant public or political implications, or substantially restructuring existing programs.

Completion of the Cabinet Submission was widely viewed as the point at which participants had fulfilled their “due diligence” surrounding policy development.

2.13.6 Formal and Informal Means of Sustaining Organizational Institutions

Participants indicated that neither the standard components of policy development nor the rules, norms, values and routines (i.e., institutions) which shape them are embedded within the Ministry through training or standard operating procedures. A current ADM explained, “when I came into the OPS, nobody said, here are the rules, here’s how you have to govern yourself. There are no standards of practice” (E1). Rather, most highlighted certain formal institutions through which policy actor conduct is codified and sustained. For example, as the governing legislation of the OPS, the *Public Service of Ontario Act* (2006) ensures that policy staff: 1) effectively serve the public, government, and legislature; and 2) function in a non-partisan, ethical and competent manner. Accordingly, most employees are required to take an Oath of Allegiance, which stipulates a series of expectations, such as that pertaining to confidentiality: “*I will not discuss or give any person any information or document that comes to my knowledge or possession by reason of being a public servant*” (*Public Service Act*, 2006, p.1)

Beyond formal institutions, respondents spoke more consistently to what the OPS has deemed ‘informal learning’, which “occurs in a structured context but without formalities such as curricula and assessment” (Ministry of Government Services, 2011, p.17). In particular, many felt their policy experience to be founded upon a *learning by doing* approach. This was described by one current Senior Policy Advisor as “figuring it out as you go along” (E9), whereas a second explained, “we sort of just throw people in and expect them to grab onto the rotating merry-go-round and hopefully jump on eventually” (E2). This feedback was notably aligned with a number of policy actor competencies. For example, employees are encouraged to *seek additional information and feedback*, including “observing the behaviour and approaches of others” (Cabinet Office, 2004a, p.18). Elsewhere, *learning from success and failures* is highlighted as a key approach to ethical behaviour: “looking toward the future and applying lessons learned is a

prerequisite to continuous individual and organizational learning” (Cabinet Office, 2011, p.20).

Mentorship was additionally highlighted as a key method through which informal learning occurs and, as a result, organizational institutions are sustained. As a former Senior Policy Advisor explained, “you learn from who you work with – here’s how you get the form you need... talk to these stakeholders instead. So, it’s definitely a mentoring approach” (E6). As such, mentorship is also notably aligned with more formal expectations for policy actor conduct. For example, *coaching* entails encouraging others and transferring knowledge to develop the skills of colleague and coworkers (Cabinet Office, 2004a, p.3). In this regard, a current Senior Policy Advisor reported, “there’s a continuum. Some people have been here for six months and some for 20 years, right? So, part of that knowledge transfer just happens through those interactions where you’re shadowing someone more senior than you” (E9). Through both the *learning by doing* and *mentorship* approach, policy staff are expected to internalize the skills and knowledge needed to operate in a confident and independent manner (Cabinet Office, 2004a).

2.14 Discussion

The present study explored the *how* and *why* of policy development within Ontario’s Ministry of Education between 2003-2018. Of particular interest were the ways individual-and organization-level factors guide information seeking undertaken to support evidence-informed policy. Accordingly, the findings shed light on some of the nuances of policy development within a ministry responsible for one of the most important modifiable determinants of health. In so doing, the possible barriers to and facilitators of the adoption of a Health Impact Assessment (HIA) tool were also identified. Together these findings provide a useful starting point for future HIA-related efforts, including implementing this tool as a required component of policy development both within Ontario and similar sub-national government contexts.

To begin, HIA proponents are advised to be aware of the policy priorities of the government or ministry in which its adoption is being sought. The policy purview of

Ontario's Ministry of Education was very clearly defined between 2003-2018, with public education system reforms remaining a key priority across successive Liberal governments. These efforts were largely guided by three overarching goals established to guide the Ministry's strategic direction – that is, improve student achievement, close the gaps in student achievement, and enhance public confidence in public education. While these were incorporated into various frameworks and mandates, and further institutionalized through amendments to Ontario's Education Act (1990), their perceived relevance differed among participants. Specifically, in contrast to policy staff 'on the ground', those closer to the 'political side' of the bureaucratic hierarchy viewed these goals as having dictated Ministry operations to the extent that all policy and program outputs were in some way aligned with at least one overarching goal. As such, they appeared to have functioned as what Workman, Jones and Jochim (2009) deem a *bottleneck of attention*, noting "this means that institutions will over-respond to some issues because they are processing serially, and under-respond to others because attention is focused elsewhere" (p.80).

Participants generally considered attention allocation to be a pragmatic strategy in light of both the information overload and time constraints faced by policymakers (e.g., Doberstein, 2017a; Greyson et al., 2011; Head et al., 2014). As such, most agreed that narrowing attention is not about being "oblivious" to other issues such as the broader determinants of health, but rather a necessary means of delivering on the priorities of elected government. Thus, whereas a rationalist approach to policy development would entail consideration of all policy alternatives and their consequences, doing so would indeed be *irrational* in light of a four-year election cycle. Rather, policy actors are *intendedly* rational in that they make goal-oriented decisions within a prescribed (i.e., *bounded*) purview (Smith & Larimer, 2017).

While broadening attention to account for health impacts would arguably constitute a 'more rational' approach to policy development, doing so is unlikely to be perceived as such if it does not further ministerial priorities (Gagnon et al., 2008). It is for this reason that both policy purview and its perceived relevance among subsets of policy actors are

critical considerations for future HIA-related efforts. For example, participants widely viewed senior staff and political officials as ‘gatekeepers’ of inter-ministerial collaboration and, at times, information seeking to inform policy development. However, where said gatekeepers do not consider health impacts to align with ministerial priorities, both the scope of information and collaboration required to account for such impacts will be constrained. Likewise, the literature reviewed identifies political agenda as a potential impediment to information seeking (e.g., O’Donoghue Jenkins et al., 2016), and indicates that senior colleagues may significantly influence the types and sources of information sought (Haynes et al., 2012; Naude et al., 2015). Similarly, securing high-level buy-in or HIA “champions” is considered critical to its adoption (e.g., Gagnon et al., 2008; Manheimer et al., 2007). It would therefore benefit HIA proponents to utilize key ministry-or government-specific priorities as the basis for nuanced “win-win” strategies targeting senior policy and political officials (Lee et al., 2013).

It is also noteworthy that the health benefits underscoring major education initiatives have traditionally been acknowledged by top officials, including Ontario’s Ministers of Education and Premiers. Between 2003-2018, a number of reform efforts, including the Child Care and Early Years Act (2014) and full-day kindergarten program (2011), were aligned with the *life course* SDoH perspective. Similarly, the ‘healthy schools’ approach built upon key foundations of the Ottawa Charter (1986) – namely, education as a prerequisite for health. While initiatives such as anaphylaxis-related laws and trans fats regulations focused on explicit health issues, others like the ‘Specialist High Skills Majors’ program, through which students could pursue alternate career-based avenues to attain their high school diplomas, were more implicitly health-oriented.

Together such objectives, which the present study has deemed the ‘health purview’ of the Ministry of Education, further highlight the importance of the strategic directions, both current and former, of governments and their ministries. Over the 15-years of interest, much of the Ministry’s health purview was prescribed by the Ontario Public Health Standards (OPHS) and, as such, the nature of inter-ministerial policy development largely aligned with the *health improvement* component of a HiAP strategy. Although not

explicitly positioned as such, this approach generally entailed “promoting the protective factors and addressing the risk factors associated with health outcomes” (OPHS, 2018, p.10). Notably absent from this purview, however, has been a *health impact* approach. Accordingly, participants indicated that while health information is routinely sought to inform health improvement initiatives, it is rarely, if ever, done so to account for the potential negative health impacts of education policies.

The Ministry of Education’s traditional health purview may have notable implications for future HIA advocacy efforts. For example, proponents may build upon the Ministry’s clear health-related values to further cultivate a policy environment conducive to healthy public policy (Boldo et al., 2011; Breeze & Hall, 2002; Delany et al., 2014; Kearns & Pursell, 2010). Doing so may entail broadening existing conceptions of health (Bernier, 2006; Knutson & Linell, 2010) or enhancing awareness of the potential health impacts of ‘non health’ sector policies (Diallo & Freeman, 2020). Such efforts would ideally comprise part of the aforementioned “win-win” approach. On the other hand, the Ministry’s existing *health improvement* orientation may dampen receptivity to HIA, especially where the current approach is widely perceived to provide a satisfactory level of benefit to students (O’Mullane, 2014; Signal, 2006). Reluctance may additionally stem from HIA’s information seeking requirements, as policy staff often already lack adequate capacity to find, appraise, and utilize information within their usual purview (Naude et al., 2015; Tait, 2016). Any existing deficiencies related to time (Head et al., 2014; Ritter, 2009), funding (O’Donoghue Jenkins et al., 2016) and information seeking support (Greyson et al., 2011) may also be further exacerbated by reforms necessitated by HIA. In this case, its proponents may seek to appeal to the economic orientation of Ontario’s major education-related initiatives (Brown, 2010), many of which have been explicitly linked to “the long-term success of Ontario’s economy” and “job creation”. Where necessary, “win-win” strategies may therefore position the preventative potential of HIA as an “economic investment opportunity” (Wesslink & Gouldson, 2014, p.18), thereby aligning its adoption and related reforms with what is typically the highest priority of government.

The Ministry of Education's overlapping education-and health-related purviews have traditionally functioned as high-level constraints at both the organization and individual levels (Workman et al., 2009). Egeberg (2003) proposes that the decision criteria employed by policy actors may further depend on their positioning within an organization's bureaucratic hierarchy. Perceptions of the relevance of the Ministry's policy purview on the day-to-day of policy work suggest that these locational differences do in fact exist. Further to this point, participants generally defined their policy-related roles and responsibilities against those of elected officials, with *decision authority* as the key differentiating factor between staff and their partisan counterparts. As such, the *logic of appropriateness* offered by March and Olsen's (1989) Normative Institutionalism was largely supported – namely, *who am I?* (non-partisan Policy Advisors or Analysts, or Assistant or Deputy Ministers), and *what is most appropriate in this situation?* (provide the best possible objective advice to inform policy development). It is notable, however, that many participants indicated the need to define policy issues themselves before related advice could be provided. This finding calls into question the true impartiality of policy staff (Eichbaum & Shaw, 2017; Nekola & Kohoutek, 2017), and further reiterates the importance of identifying both the contexts and factors that shape predominant perceptions of policy issues, and their implications in terms of evidence-informed policy (e.g., Tait, 2016).

Participant feedback indicated that information seeking is central to the provision of policy-related advice and, further, that it is largely *purposive* in that the information anticipated to be used is most often sought. This approach appears to account for the significant time constraints faced by policy actors (Greyson et al., 2011; Head et al., 2014; Naude et al., 2015; Tait, 2016), which were widely cited as a recurring barrier to more thorough and systematic information retrieval. Policy development more generally was also said to be highly contingent on factors such as issue familiarity, cost, political agenda, government turnover, and senior management.

Together these sorts of contingencies appear to simultaneously impede and facilitate information seeking, thereby supporting both the '*glass half full*' and '*glass half empty*'

campus of Bounded Rationality introduced at the outset of this chapter. This may be illustrated through consideration of the routine components (i.e., “due diligence”) of policy development highlighted by participants – all of which were notably information based. For example, many indicated that *jurisdictional scans* are typically limited to geographical regions considered comparable to Ontario, thereby suggesting at least some reliance on selection criteria (Tait, 2016). Although the perceived benefits of this strategy are understandable, doing so risks overlooking potentially relevant information (Haines et al., 2012; Tait, 2016) including, for example, evidence of the negative health impacts of similar policies within excluded regions. Moreover, while jurisdictional scans are a widely preferred information source among policy actors (Greyson et al. 2011; Ritter, 2009), there may be little consideration of the type and quality of evidence used to inform policies implemented elsewhere (O’Donoghue Jenkins et al., 2016). While this latter point was not an explicit focus of the interviews conducted for the present study, there was no indication that such details are considered. Generating understanding and confidence surrounding HIA may therefore entail efforts to demonstrate how this tool may facilitate such considerations (e.g., through the *scoping* phase), as well as the benefits of doing so (Diallo & Freeman, 2020). Keeping in mind the time constraints faced by policy actors, both the retrieval and appraisal of inter-jurisdictional information may be aided by more formal technical and resource supports, such as dedicated units within government (e.g., Delany et al., 2014) or academic institutions (e.g., Harris & Spickett, 2011). While these support mechanisms may further enhance the oft-desired accessibility of policy-relevant information (Naude et al., 2015; Ritter, 2009), their required time, financing, and personnel reiterates the importance of securing buy-in at the highest possible levels of government (Delaney et al., 2014).

Other routine components pose similar implications. In discussing *policy referencing* in particular, participants emphasized the “evolutionary” nature of policy development and implementation, noting that neither tends to have distinct “stop and start dates”. While this strategy had a number of perceived benefits, including available baselines to guide incremental improvement efforts, its drawbacks were also noted to entail “lack of innovation”, and building upon “outdated or problematic policies”. These latter points

highlight the nature and impact of *path dependency*, which Christensen et al. (2020) deem “a double-edged sword that both offers possibilities and imposes constraints” (p.76). For example, participants indicated that education policies are typically informed through consultations with a narrow subset of “education-based” stakeholders. While the perceived reliability of previous information sources may facilitate the retrieval process (Tait, 2016), it also necessarily limits the stakeholder perspectives sought (Ritter, 2009). Such constraints are arguably more pronounced where existing ministerial objectives are routinely built upon (O’Donoghue Jenkins et al., 2016), and may be further exacerbated by the time constraints and ‘gatekeeper’ preferences discussed earlier. Similarly, as a highly-valued strategy among respondents, *informal networking* generally entailed snowballing colleague networks (Haynes et al., 2012) to indirectly inform education policies. As such, most had not consulted formally or informally with health-oriented policy actors or stakeholders.

Policy referencing calls to attention how and why certain information sources are monopolized. As Cairney (2012) explains, “most government responses are not proportionate to the ‘signals’ that they receive from the outside world. They are either insensitive or hypersensitive to policy-relevant information” (p.198). In this regard, consideration of *potential* health impacts is one, arguably less apparent, ‘contour’ of multifaceted education policies (Workman, Jones & Jochim, 2009). Policy actors may therefore overlook this contour simply because attention is allocated elsewhere. On the other hand, they may intentionally monopolize certain information sources so as to “insulate the decision-making process from a wider audience” in the interest of a political agenda (Cairney, 2012, p.178) (see also Haynes et al., 2012; Tait, 2016). Path dependency may be ideal in this case, and receptivity to tools like HIA, designed to bring certain types of information to the forefront of policy development, may be diminished (Mattig et al., 2015; O’Mullane, 2014). In less calculated instances, HIA-related reforms may simply conflict with longstanding institutions (e.g., norms, routines) or, similarly, existing ‘silos’ may prevent the degree of horizontal collaboration necessary for HIA (Lee et al., 2013).

Finally, feedback regarding *risk analysis* indicated that, although required, this process remains highly variable and unsystematic. Moreover, predominant perceptions of ‘risk’ among participants did not explicitly include health and wellbeing, but rather were limited to stakeholder reactions, public sentiment, and financial considerations. These and other insights surrounding the “due diligence” of policy development were notably reflective of the embedded components of Cabinet Submissions – that is, evidence, jurisdictional scans, consultation and collaboration, policy referencing, and risk analysis. While the latter in particular requires staff to report findings from various impact analyses (e.g., financial, OPS operations), *health impact* considerations have traditionally been excluded. While the reasons for this oversight remain unclear, participants generally agreed that the Cabinet Submission has typically guided policy development. Given its clear impact on the perceptions and conduct of policy staff, it therefore represents an ideal *formal* institution (March & Olsen, 1989) into which a required HIA component could be integrated (Banken, 2001; Breeze & Hall, 2002; Lee, 2013). Doing so would not only broaden the scope of health information required to inform policy development, but may also avoid the major structural or procedural reforms often necessitated by HIA (e.g., Manheimer et al., 2007; O’Mullane, 2015). Moreover, it would ensure potential health impacts are considered at Cabinet level, which was widely agreed upon as the “last stop” to account for the possible shortcomings of *satisficing*, and ensure that the “best possible” outcome is achieved. While presenting evidence of health impacts does not ensure such considerations will be integrated into policy decisions, awareness of the value and utility of HIA may be enhanced among staff and officials alike through the Ministry’s predominant *learning by doing* approach. The *mentorship* approach would, in the ideal, similarly function to cultivate a policy environment conducive to healthy public policy and, with time, the institutionalization of HIA.

Findings from the present study highlight a number of possible avenues for future research. Perhaps most notably, HIA-related advocacy would likely benefit from concrete evidence of its preventative potential and, similarly, demonstrated economic benefits of preventative policy approaches. Next, while the present study has identified possible barriers to and facilitators of HIA adoption, findings were derived from a social policy-

oriented sector. The nuances of policy development and HIA adoption alike may be further enhanced through exploration of more economically-oriented sectors wherein policy actors often view their work as less proximate to health and health outcomes (e.g., Gagnon et al., 2008; Lavis et al., 2003). Finally, there is a notable dearth of evidence pertaining to the impacts of organizational context on information seeking among government policy actors. This body of literature may therefore benefit from future insights into how and to what extent the *task environment* shapes judgments and decisions surrounding purposive information seeking among both non-partisan staff and political officials.

2.15 Study Strengths and Limitations

Case study findings are often considered limited in terms of their generalizability across contexts. However, the norms, values, and routines that shape policy actor conduct are theorized to be organization-specific (March & Olsen, 1989). Similarly, both the methodological design and implementation of HIA are highly contextual (Shankardass et al., 2014). Strategies pertaining to its use should therefore be tailored to specific administrative arrangements and cultures (Bernier, 2006). Nonetheless, the present study was guided by an integrated framework comprised of two theories considered highly relevant to bureaucratic policymaking (Peters, 2015). Such frameworks may support the comparison of findings across bodies of work that have used these or similar lenses (Miles & Huberman, 2004; Yin, 2009).

The sample size of nine participants should also be noted. Recruitment for this study followed the 2018 election of a new provincial government, at which time there was significant confidentiality surrounding government processes and initiatives. It should thus be noted that participant insights surrounding the routine components of policy development may not be shared by others within the Ministry. Moreover, the issues of recall bias may also be a limiting factor. However, the sample included both former and current senior staff, seven of whom had, at the time of interviewing, been immersed within the policy environment for more than five years. Their insights were also

supplemented with a range of documents and frameworks spanning the 15-year period of interest, thereby enhancing the credibility of the findings.

2.16 Conclusion

The present study explored the *how* and *why* of intra-ministerial policy development within Ontario's Ministry of Education between 2003-2018. In so doing, the many nuances of this process and its information-seeking components have been identified. Key finding may usefully inform future efforts to implement HIA as a required component of government policymaking. In particular, it is important that proponents appreciate that a range of information types and sources are sought to inform 'non-health' sector policies, and that it is not necessarily *irrational* that health information may be overlooked. Rather, information seeking is highly contingent on a range of factors and circumstances that may simultaneously facilitate and impede this process. As the most significant of these are largely non-negotiable, including ministerial priorities, time limitations, and longstanding institutions, it is critical that these 'realities' serve as the basis for nuanced win-win strategies. Where possible, these strategies should demonstrate to officials how HIA would improve policy development and its subsequent outputs. Moreover, they should identify where within existing structures and processes HIA may be effectively integrated. Such considerations first require an in-depth understanding of both the task environment and the predominant perceptions among policy actors therein. As the present study has demonstrated, while the interactions between these variables typically benefit intra-ministerial policy objectives, they may simultaneously impede the broader purview necessary to identify and mitigate the penitential negative health impacts of non-health sector policies.

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CHAPTER 2

3 Inter-ministerial policy development between health and non-health ministries of the Ontario government: How might existing structures and processes facilitate or impede the implementation of a provincial Health Impact Assessment protocol?

Healthy Public Policy (HPP) is premised on the understanding that population health is profoundly shaped by the policies of non-health government sectors (Milio, 1981). To adopt HPP requires that governments actively utilize public policies as mechanisms to create, modify, or sustain health enhancing environments (Government of South Australia, 2011). One means of doing so is through direct action on the social determinants of health (SDoH), such as education, housing, and income distribution (Raphael, 2016). These and other interrelated variables comprise societal living conditions that may enable or constrain individual and group capacities to maximize their health potentials (Beaglehole et al., 2004). Given its focus on multiple government sectors wherein ‘health’ is not often a primary policy objective, HPP may be usefully discerned from the *health policies* of traditional public health or healthcare realms (Careyet al., 2014). While health policies are significant predictors of population health status, they are ultimately less impactful than the SDoH (Chircop et al., 2015).

Health in All Policies (HiAP) is a predominant framework through which both HPP and the SDoH approach may be promoted (World Health Organization [WHO], 2014). HiAP offers at least two modes to create, modify, and sustain health enhancing environments. One mode aims to *improve* overall health through comprehensive action between sectors on given health issues. The other seeks to systematically identify and *mitigate* the potential negative health impacts of non-health sector policies (Fafard, 2013; Ollila, 2011). A key difference between these is their respective scope of consideration, with the latter driven by a broad SDoH focus rather than narrow concern for an explicit health problem (National Collaborating Centre for Healthy Public Policy [NCCHPP], 2017).

Mitigation therefore presents a unique challenge for governments, as it requires integrating health considerations into the policy decisions of non-health sectors.

One means of facilitating this process is through the use of Health Impact Assessment (HIA) – a tool to identify and address potential negative health impacts of proposed public policies. By broadening the scope of health information that proactively informs policy development, policymakers may avoid introducing a degree of foreseeable harm to population health. A critical caveat, however, is that actually integrating said considerations into policy decisions remains at the discretion of non-health sector policy officials. HIA must therefore be viewed as an adjunct to policy environments conducive to HPP (NCCHPP, 2017).

As oft-designated stewards of their government's HiAP approach, ministries of health may play a critical role in fostering said environments (Kickbusch & Buckett, 2010). As St-Pierre (2008) explains, stewardship “puts the accent on the role that ministries of health must play in order to lead other sectors ... toward taking their responsibilities for population health” (p.13). This approach has been adopted by a number of jurisdictions. For example, in 2008, South Australia's Department of Health established a dedicated HiAP Unit to provide content expertise and technical support to other sectors mandated to undertake *health lens analysis* (Government of South Australia, 2011). Similarly, the Canadian province of Québec legislated HIA under section 54 of its Public Health Act (2001), and assigned responsibility for HIA coordination to the public health directorate of the Ministry of Health and Social Services (St-Pierre, 2013). In general, stewardship entails supporting the policy objectives of other sectors through provision of advice, resources and procedural expertise, rather than imposing a ‘health agenda’ (Kickbusch & Buckett, 2010).

In Canada, the majority of health and social policy initiatives fall within the jurisdiction of provincial and territorial governments (Howlett & Newman, 2010). With the exception of Québec, however, HIA use is lacking at this policy level (Linzalone et al., 2018). While the Ontario government in particular has indicated some interest in this approach over the last decade (e.g., d'Amour et al., 2009; Lysyk, 2017; St-Pierre, 2013),

implementation efforts have continually stagnated. Most recently, Ontario's Ministry of Health indicated its plan to implement an impact assessment approach, '*where appropriate*', by December 2019 (Lysyk, 2019, p.149). This initiative had not yet been implemented by the end of 2020 (Lysyk, 2020).

Accordingly, the present case study sought to explore the traditional nature of inter-ministerial policy development between health and 'non-health' ministries of the Ontario government, including how and to what extent this approach has aligned with the *improvement* and/or *mitigation* components of a HiAP framework. As prospective stewards of a provincial HiAP strategy, the case study focused on perceptions of the roles and responsibilities of the Ministry of Health among its current and former policy staff. Together the findings contribute to an enhanced understanding of contexts and factors that shape sub-national government receptivity to the adoption and sustained implementation of HIA.

3.1 'Boundary-Spanning' Dynamics: Where does HIA fit?

While details of HIA's application and technical elements are highly contextual, its most widely cited definition describes it as "a combination of procedures, methods and tools by which a policy... may be judged as to its potential effects on the health of a population, and the distribution of those effects" (WHO, 1999, p.4). In this case, HIA is conceptualized as a tool to inform policy development – that is, the stage at which various actors and stakeholders formulate possible solutions to a policy problem for consideration by senior officials (Fafard, 2008). Rather than prescribing health-related decisions, HIA proposes actions to both maximize the health benefits of proposed public policies, as well as mitigate their potential negative health impacts.

Despite its various definitions, methodologies, and contexts of use, there is general consensus surrounding the six structured steps of HIA, which include: 1) *Screening* available evidence to determine whether an assessment is appropriate; 2) *Scoping* the details of the assessment, including affected populations, relevant stakeholders, and

priority considerations; 3) *Assessing* the proposed policy direction to identify and characterize health impacts, and develop strategies to mitigate potential negative outcomes, where necessary; 4) *Reporting* the details of the previous steps, including key findings; 5) *Monitoring* the accuracy of predictions and the effectiveness of mitigation strategies; and 6) *Evaluating* the HIA process and the impact of its recommendations for future improvement (McCallum et al., 2015).

While intersectoral efforts are integral to HiAP, its ‘*health improvement*’ and ‘*health impact*’ components entail different boundary-spanning work. As earlier noted, this difference is underscored by their respective scopes of consideration, with HIA driven by a broad SDoH focus rather than a narrowed concern for explicit health issues (NCCHPP, 2017). Donahue’s (2004) eight dimensions to categorize intersectoral arrangements help clarify this critical distinction. For example, ‘*focus*’ specifies whether arrangements are limited to a certain objective (i.e., health improvement) or encompassing of a broad range of issues (i.e., health impact). Moreover, the ‘*problem versus opportunity driven*’ dimension conceptualizes arrangements as defensive (i.e., solves a joint threat – health impact) or offensive (i.e., pursues a joint opportunity – health improvement). Other dimensions appear relevant to both HiAP components. For example, ‘*initiative*’ considers ‘who is leveraging from whom?’ and ‘who defines goals?’ In this regard, HiAP stewards must seek to further the policy objectives of non-health sectors rather than impose a ‘health agenda’ – a phenomenon commonly deemed *health imperialism*.

3.2 Who Shall do What: Implications of Organizational Structure

The division of labour into distinct policy jurisdictions is a defining characteristic of political systems (Baumgartner et al., 2000). The boundaries that separate one policy jurisdiction from any other are said to demarcate not only *who is ‘in’ and who is ‘out’* (O’Flynn et al., 2010), but also *who shall do what* (Christensen et al., 2020). Formal organizational structure – that is, the design and dimensions of government bureaucracy – may therefore significantly shape policy processes and related outputs (Egeberg, 2007).

Within a Parliamentary system, formal structures are organized in two ways. First, *horizontal* specialization establishes how and to what extent certain policy areas are linked (Christensen et al., 2020). In so doing, responsibility for coordination and conflict resolution moves upward within the hierarchy. For example, through Cabinet, various Ministers may engage in horizontal coordination to shape the ‘common policy’ of government (Christensen et al., 2020). On the other hand, *vertical* coordination takes place through superior-subordinate relationships; whereas a Minister is responsible to Parliament for his or her ministry and its sub-units, the activities of said units are typically coordinated by ministerial division leaders (Egeberg, 2007).

Formal organizational structure appears to influence policy actors’ understandings of their own roles and responsibilities surrounding inter-ministerial efforts. In particular, senior officials tend to identify more closely with central government and have extensive horizontal networks, and are thus more engaged with broader system-wide agendas and concerns. Conversely, policy staff view themselves as division or branch ‘representatives’ whose foci are limited to a narrow set of policy issues (Egeberg, 2003; 2007). As Fafard (2013) notes, *leadership* is the most commonly identified enabler of integrated governance. Political and administrative officials who value and prioritize ‘boundary spanning’ policy work must therefore signal its perceived importance to lower-level public servants (Egeberg, 2007; O’Flynn et al., 2010).

3.3 Policy Problems & Solutions: Implications of Organizational Culture

Policy work is conducted within a task environment defined by certain assumptions, beliefs, values and routines (March & Olsen, 1989). Together these comprise a unique organizational culture that serves as a ‘behavioural blueprint’ for policy actors by specifying priority issues, alternative courses of action, and decision processes (Buick, 2010). Whereas the division of labour establishes *who does what*, culture prescribes *how* policy work is undertaken.

Culture is reflected within formal and informal processes and structures (Belkhodia et al., 2007). As such, it is enduring to the extent that policy actors become “more or less hermeneutically ‘programmed’” by their respective organizations (Sending, 2002, p.452). As with the division of labour, the normative elements of organizational culture both enable and constrain policy work, thereby permitting some degree of deeply embedded functionalism (Christensen et al., 2020 et al., 2020). The culture which shapes the beliefs and behaviour of policy actors is thus shared and reinforced by those same actors (Belkhodia et al., 2007).

As Kickbusch and Buckett (2010) observe, health sectors “do not own the ways of addressing the roots of health problems, as the answers are not medical or clinical, but environmental and social” (p.3). To some degree, receptivity to HiAP initiatives may therefore depend on the extent to which a health department’s organizational culture aligns with the inherently intersectoral nature of the SDoH. Of particular relevance are shared views of health and society (Shankardass et al., 2010), as these may shape and ultimately institutionalize certain approaches to health promotion and protection rather than others (Government of South Australia, 2017). For example, Raphael (2011) identifies seven SDoH discourses along a spectrum, where *Discourse 1* emphasizes the provision of health and social services to at-risk groups, overlooks the sources of ‘adverse’ SDoH, and reinforces predominant biomedically-oriented solutions. Each remaining discourse embraces an increasingly broader perspective regarding the antecedents of health and illness, with those toward the opposite end of the spectrum highlighting public policy (*Discourse 6*) and political activism (*Discourse 7*) as mechanisms to ameliorate adverse SDoH. Elsewhere, limited political commitment is said to underscore a tendency to adopt behavioural rather than policy-oriented public health interventions (Kendall, 2010). As Fafard (2013) contends, it is therefore necessary to consider “the extent to which what is being done (or not done) is rooted in the particularities of the underlying political and administrative system” (p.16).

3.4 Bounded Rationality: Attention Allocation and Policy Agendas

Simon (1997) theorized that although the decision behaviour of policy actors is intendedly rational, it is shaped by various cognitive, emotional and environmental factors. Bounded Rationality therefore challenges the once predominant views of instrumental-comprehensive decision making, which posit that organizations have consistent and unambiguous goals, and the ability to consider a full range of alternative courses of action and their respective consequences. Organizational culture and structure, as discussed above, are but two factors that have rendered this approach an unattainable ideal (Cairney, 2016).

Instead, attention allocation may be significantly shaped by a task environment (Egeberg, 2007). As such, knowledge of policy problems, alternatives, and outcomes among individuals may be aggregated, to some degree, to the organizational level (Workman et al., 2009). While structure and culture function to reduce ambiguity surrounding policy jurisdiction (Olsen, 1991), they can also lead to “difficulty in seeing one’s own activity and role in a wider perspective” (Christensen et al., 2020 et al., 2020, p.46). This is reflected in two camps of Bounded Rationality –the ‘*glass half full*’ versus the ‘*glass half empty*’ orientations (Bendor, 2010).

Both camps have closely related implications for HIA as a harm mitigation strategy. For example, organizational structure and culture may reflect and reinforce certain conceptualizations of ‘health’ (and vice versa), and thus influence how and to what extent ‘health information’ is not only *sought* by non-health sectors, but actually *integrated* into their policy decisions. Thus, while structure and culture may enable or facilitate intra-ministerial objectives, they may also constrain attention to their potential health impacts. Similar issues extend to health departments which, as HIA stewards, must be privy to their own policy agendas as well as those of non-health sectors. Whereas organizational structure and culture may both shape and enable intra-ministerial approaches to health promotion and protection, they may also constrain necessary attention to the broader determinants owned by non-health sectors.

3.5 Problem and Research Objectives

Canada's provincial and territorial governments have significant authority over the design of health and social policies understood to significantly shape population health (Howlett & Newman, 2010). Despite some momentum surrounding HiAP-related initiatives in Ontario, however, Québec remains the only Canadian province to have institutionalized HIA at the provincial level (Lysyk, 2020). This research therefore stemmed from the basic question of, *why do some governments but not others adopt HIA?*

The present undertaking was designed in light of prominent commentaries regarding the need for interdisciplinary policy research (e.g., Greer et al., 2017) and, relatedly, an enhanced practical understanding of policy decision-making among academics, public health professionals, and health promoters (e.g., Fafard, 2008; Oneka et al., 2017; Sá & Hamlin, 2015). As efforts to introduce HIA may entail some degree of reform to existing policy processes, it would arguably benefit HIA proponents to better understand *how* inter-ministerial policy development occurs, and *why* it occurs as such (Cairney, 2015; Fox, 2006). This is especially so in light of evidence suggesting that, under certain contexts and conditions, HIA can successfully influence policy decisions (e.g., Dannenberg, 2016; Haigh et al., 2013).

This study therefore sought to open the 'black box' of government policy by exploring the traditional nature of policy development between health and 'non-health' ministries of the Ontario government. Of particular interest were the perceptions of Ministry of Health staff regarding their own 'boundary spanning' roles, as well as any predominant views of the Ministry's policy purview more generally. The contexts and factors underscoring these insights were also explored. The aim of this study was to expound the nuances of policy development in 'real life' contexts to account for why governments are more receptive to certain approaches to health promotion and protection rather than others. Two research questions were addressed:

1. How and to what extent do individual-and organization-level determinants interact to shape routine inter-ministerial policy development between health and ‘non-health’ ministries of the Ontario government?
2. What structures, processes, and mechanisms are in place to enable or impede HIA implementation at the provincial level?

3.6 Literature Review

HIA Legislation. Practitioners, policymakers and researchers have largely deemed legislation to be one of the most robust mechanisms with which to embed HIA into policy and decision processes (Lee et al., 2013). Québec appears to have exemplified this approach when the provincial government mandated impact assessments via section 54 of its Public Health Act (2001) (Bernier, 2006; Boldo et al., 2011; Diallo & Freeman, 2020; Gagnon et al., 2008). While this remains Canada’s only longstanding HIA-related legislation, similar enactments have occurred internationally. For example, the Swiss canton of Geneva integrated HIA into its Health Act (2006) (Mattig et al., 2015), whereas the Australian state of Victoria added HIA to its Public Health and Wellbeing Act (2008) (Harris & Spickett, 2011). Elsewhere, the utility of legislative frameworks is questioned. For example, experiences in Slovakia suggest that HIA legislation preceded the “conditional preparedness” (i.e., capacity) necessary for its successful implementation (Manheimer et al., 2007; O’Mullane, 2014). Thus, while a lack of binding requirements has been identified as a significant barrier to HIA adoption (Kearns & Pursell, 2010; Knutsson & Linell, 2010; Mattig et al., 2015), the literature also stresses that legal provisions in themselves do not ensure HIA use (Gagnon et al., 2008; Harris & Spickett, 2011; Lee et al., 2013; O’Mullane, 2014).

HIA Champions. In examining Québec’s experience with HIA, Gagnon (2008) concludes, “legal ‘constraint’ ... must necessarily be accompanied by political and administrative leadership” (p.19). There is widespread consensus surrounding the critical importance of such high-level “champions” (Boldo et al., 2011; Harris & Spickett, 2011; Kearns & Pursell, 2010; Knutsson & Linell, 2010; Manheimer et al., 2007; Lee et al.,

2013; O'Mullane, 2014, Put et al., 2001; Walpita & Green, 2020). In Québec, for example, the Ministry of Health and Social Services (MHSS) established an intraministerial committee to increase awareness of both section 54 of the Public Health Act (2002) and healthy public policies (Dialloa & Freeman, 2020; Gagnon, et al., 2008). In New Zealand, the Public Health Advisory Committee was central to elevating HIA onto the policy agenda, having both advised the Health Minister of its potential value, and developed a guideline to facilitate its use (Signal et al., 2006). At a broader level, South Australia's Premier and Cabinet exerted significant influence to elevate Health Lens Analysis (HLA) onto the political agenda (Delany et al., 2014), whereas Sweden's Parliament (Berensson & Tillgren, 2017) and the Wales Assembly Government (Breeze & Hall, 2002) explicitly endorsed HIA to improve population health. Finally, international efforts such as the WHO Healthy Cities programme led to local HIA adoption in Galway, Republic of Ireland (Kearns & Pursell, 2010) and Trnava, Slovakia. In the latter jurisdiction, public officials felt that without the WHO's endorsement, HIA would not have been supported (Manheimer et al., 2007).

A lack of high-level HIA champions has notably hindered HIA implementation (Harris & Spickett, 2011; Lee et al., 2013; O'Mullane, 2014; Put et al., 2001; Signal et al., 2006). For example, Banken (2001) highlights the impact of "policy instability" in British Columbia, where HIA implementation was a high priority for several years. Following the 1996 re-election of the provincial New Democratic Party (NDP), however, a radical shift in the predominant approach to health policy (i.e., away from an SDoH focus and toward managerial accountability), along with significant structural changes to the Ministry of Health, diminished the importance of HIA on the policy agenda (Banken, 2001). Where HIA has been adopted, governments have recognized the broad social, economic, environmental, and physical determinants of health and wellbeing (Banken, 2001; Bernier, 2006; Breeze & Hall, 2002; Knutsson & Linell, 2010; Put et al., 2001; Signal et al., 2007; Walpita & Green, 2020). Conversely, barriers to HIA implementation include predominantly biomedical views of health and its antecedents (Breeze & Hall, 2002; Lee et al., 2013; Manheimer et al., 2007; O'Mullane, 2014; Signal et al., 2006) and narrow policy purviews of government health sectors (Berensson & Tillgren, 2017).

Value Alignment. The theoretical underpinnings of HIA have also tended to align with the stated values of societies and governments where it has been implemented. For example, New South Wales' broad societal values of democracy, sustainability, and equity are considered key drivers of its HIA adoption (Delany et al., 2014), whereas a desire to protect vulnerable groups in Slovakia contributed to early HIA efforts (O'Mullane, 2014). Moreover, Wales (Breeze & Hall, 2002; Walpita & Green), the Republic of Ireland (Kearns & Pursell, 2010), and South Australia and New Zealand (Delany et al., 2014) formally committed to collaborative government for population health prior to adopting HIA. Other governments have sought to enhance their equity-oriented (Breeze & Hall, 2002; Delany et al., 2014) and community participation (Signal et al., 2006) approaches to policy development. Government documents endorsing HIA have thus framed its use as an enabler of healthy public policy (Harris & Spickett, 2011) or Health in All Policies (HiAP) (Delany et al., 2014; Mattig et al., 2015; Walpita & Green, 2020), a tool for sustainable development (Berensson & Tillgren, 2017; Breeze & Hall, 2002; Delany et al., 2014; Knutsson & Linell, 2010; Mattig et al., 2015; Walpita & Green, 2020), a means of addressing inequities (Berensson & Tillgren, 2017; Put et al., 2001; Signal et al., 2007) and a facilitator of intersectoral governance (Bernier, 2006; Delany et al., 2014; Kearns & Pursell, 2010).

'Non-Health' Priorities. The priorities of governments broadly or 'non-health' sectors in particular may also limit the scope of HIA use, or impede its implementation altogether (Lee et al., 2013; Put et al., 2001). For example, South Australia's overarching HiAP framework, of which HIA is a part, narrowly aligns with the political agenda of the day (Delany et al., 2014). Moreover, Gagnon (2008) notes that HIA is rarely applied to bills or regulations proposed by Québec's more economically oriented departments and agencies, whereas experiences in Slovakia (Manheimer et al., 2007; O'Mullane, 2014) and Switzerland (Mattig et al., 2015) call to attention potential HIA opposition among pro-business and private sector interests. Research from Wales (Breeze & Hall, 2002) and Sweden (Knutsson & Linell, 2010) indicates that policy actors beyond health and social sectors may also perceive their work to have few, if any, health implications. In this regard, 'urgent matters' (Put et al., 2001) and 'institutional visions' (Gagnon, 2008) are

typically prioritized within distinct government departments, which may embed ‘siloes’ (Breeze & Hall, 2002) or ‘drainpipe’ (Knutsson & Linell, 2010) approaches to policy development. In such cases, institutional cultures, routines, values or traditions may further hinder HIA implementation (Breeze & Hall, 2002; Kearns & Pursell, 2010; Knutsson & Linell, 2010; Manheimer et al., 2007; O’Mullane, 2014). For example, Signal et al. (2006) found that among central government agencies in New Zealand, existing policy processes were widely perceived to sufficiently account for the potential health impacts of policies. On the other hand, Gagnon (2008) notes that differing perspectives or rationales across government departments may lead to conflicting solutions to the same problem. Perceptions of the bureaucratic nature of HIA may also cause resistance to its uptake (Berensson & Tillgren, 2017; Signal et al., 2006).

HIA Capacity. Finally, capacity building to generate HIA-related understanding, experience and confidence is widely considered critical to its use (Kearns & Pursell, 2010; Signal et al., 2006). As noted by Lee et al. (2013), “even if there is strong political commitment, lack of support in budget, time and training can be a barrier to implementation” (p.21). International approaches to this undertaking appear fairly consistent. To begin, preliminary expertise and advice has typically been sought to both demonstrate the value of HIA, and inform the early development of HIA methodologies, toolkits, and guides (Banken, 2001; Berensson & Tillgren, 2017; Kearns & Pursell, 2010; Knutsson & Linell, 2010; Mattig et al., 2015; O’Mullane, 2014; Put et al., 2001; Signal et al., 2006). This process is often informed by evidence of interjurisdictional experiences with HIA (Berensson & Tillgren, 2017; Breeze & Hall, 2002; Harris & Spickett, 2011; Manheimer et al., 2007; O’Mullane, 2014; Put et al., 2001; Signal et al., 2006). Preliminary tools are then typically pilot tested (Breeze & Hall, 2002; Harris & Spickett, 2011; Mattig et al., 2015; Manheimer et al., 2007), for example via case studies of select policy issues (Knutsson & Linell, 2010; Signal et al., 2006) or experimental screening of policy proposals (Put et al., 2001). The literature also highlights the critical importance of both enhancing policy actors’ awareness of the determinants of health, and their familiarity with HIA processes (Lee et al., 2013). This has largely been addressed through the formal training of personnel both within and beyond government health

sectors (Banken 2001; Berensson & Tillgren, 2017; Breeze & Hall, 2002; Dialloa & Freeman, 2020; Harris & Spickett, 2011; Kearns & Pursell, 2010; Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006; Walpita & Green, 2020), as well as provincial, national, and international workshops (Banken, 2001; Berensson & Tillgren, 2017; Harris & Spickett, 2011; Kearns & Pursell 2010; O’Mullane, 2014; Put et al., 2001; Signal et al., 2006). Both strategies require considerable time and engagement (Berensson & Tillgren, 2017; Knutson & Linell, 2010; O’Mullane, 2014), especially to foster a culture of collaboration (Boldo et al., 2011; Breeze & Hall, 2002; Delany et al., 2014) or an ethos of healthy public policy (Kearns & Pursell, 2010). As such, technical and resource support for HIA are often provided by designated personnel (Put et al., 2001; Signal et al., 2006) within government (Banken, 2001; Bernier, 2006; Delany et al., 2014; Kearns & Pursell, 2010), non-government (Mattig et al., 2015), or academic (Delany et a., 2014; Harris & Spickett, 2011) organizations or institutions. Québec’s National Public Health Institute (i.e., Institut National de Santé Publique du Québec or “INSPQ”) is a widely referenced centre of expertise that has supported the MSSS in applying section 54 of the Public Health Act, including informing the Minister of potential population health impacts of public policies (Gagnon, 2008). Alternatively, the Social Health Impact Assessment Team at Monash University in Victoria, Australia facilitated a ‘learning by doing’ approach through HIA training for public health staff (Harris & Spickett, 2011). Government funding to support both preliminary HIA work and its actual implementation is needed (Breeze & Hall, 2002; Gagnon, 2008; Kearns & Pursell, 2010; Put et al., 2001; Signal et al., 2006; Walpita & Green, 2020).

Failure to facilitate and support HIA capacity poses a significant barrier to both its initial implementation and sustained use. Such failure has entailed inadequate training, guidelines, time, and financing as the necessary precursors for conducting HIA (Breeze & Hall, 2002; Harris & Spickett, 2011; Kearns & Pursell, 2010; Knutsson & Linell, 2010; Lee et al., 2013; Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006). Lack of HIA capacity may further stem from factors such as weak high-level support (Harris & Spickett, 2011) or poor methodological clarity (O’Mullane, 2004). In some instances, preliminary HIA frameworks or plans have been established without concrete strategies

for future uptake among potential users (Banken, 2001; Kearns & Pursell, 2010). For example, HIA legislation in Slovakia was implemented without accompanying technical support (O'Mullane, 2014), whereas language barriers have thwarted widespread HIA adoption in various cantons of Switzerland (Mattig et al., 2015), Slovakia (O'Mullane, 2014) and Canadian provinces beyond Québec (Bernier, 2006). These potential issues can be accounted for during preliminary phases of methodological development (Signal et al., 2006) and through technical and resource support venues (Lee et al., 2013). Additional primacy should be given to establishing formal mechanisms for intersectoral collaboration (Breeze & Hall, 2002; Kearns & Pursell, 2010; Manheimer et al., 2007). For example, policy confidentiality has been cited as a barrier to the horizontal or 'boundary spanning' work necessary for HIA (Banken, 2001; Signal et al., 2006). Accordingly, integrating HIA into existing communication structures or processes, including Cabinet meetings or submissions, and bureaucratic policymaking, may facilitate its implementation (Banken, 2001; Breeze & Hall, 2002; Lee et al., 2013; Signal et al., 2006).

3.7 Integrated Theoretical Approach

The present study explored the ways policy actor perceptions and understandings (i.e., micro-level phenomena) may interact with ministry-specific rules, norms and values (i.e., meso-level phenomena) to embed certain approaches to inter-ministerial policy development rather than others. Belkhodja and colleagues note, "these two levels of analysis influence each other and cannot be disassociated" (Belkhodja et al., 2007, p.380). The present multi-level exploration was therefore guided by an integrated theoretical framework informed by the core tenets of *Bounded Rationality* (Simon, 1961) and *Normative Institutionalism* (March & Olsen, 1989), both of which are highly pertinent to the study of bureaucratic policymaking (Peters, 1998).

Bounded Rationality focuses on the ways in which decision behaviour is affected by various factors and circumstances within a task environment, including attention allocation, information and resource availability, and emotion. Accordingly, the theory is premised on four principles: 1) *Intended Rationality* states that individuals are goal

oriented and act as rationally as possible. Thus, decision behaviour that is constrained (i.e., *bounded*) is not necessarily *irrational*; 2) *Adaptation* suggests that actors rely on decision-making heuristics which, over time, increasingly reflect the task environment to become “basically rational” (Jones, 2003, p.398); 3) *Uncertainty* states that ambiguities constantly permeate the thought process; and 4) *Trade-Offs* posits that actors choose alternatives that are “good enough” rather than completely optimal. Simon deemed this phenomenon *satisficing* – that is, decisions which both satisfy and suffice (Jones, 2003).

Normative Institutionalism pertains to the ways formal and informal institutions, including norms, rules, values and routines, become embedded within an organization and ultimately shape policy actor conduct. Examples of formal institutions include bureaucratic structures and legislative frameworks, whereas informal institutions may involve tacit knowledge or actor networks (March & Olsen, 2008). Central to this theory is a *logic of appropriateness* that guides boundedly rational actors according to four key considerations: 1) *What kind of situation is this?* Environmental and contextual signals are interpreted through a combination of complex reasoning, formal and tacit knowledge, and past experience; 2) *Who am I?* Actors determine the duties and obligations that constitute appropriate behaviour according to both their professional role and the situation at hand; 3) *How appropriate are different actions for me in this situation?* Formal and informal rules encode appropriate action once a situation is defined and matched to professional duties; and 4) *Do what is most appropriate.*

A conceptual framework may benefit case studies by 1) identifying relationships based on theory; and 2) providing ‘intellectual bins’ to organize and analyze data (Miles & Huberman, 2014). The core tenets of the integrated framework informed all study components, including the design of the interview guide, thematic data analysis, and the interpretation of findings.

3.8 Methodology

Case studies permit in-depth insights into the *how* and *why* of contemporary phenomena (Yin, 2009), and are a suitable methodology for better understanding *processes* (Merriam,

1998). The present study sought to explore Ontario's traditional approach to inter-ministerial policy development (i.e., the *how*) as a partial result of micro-and meso-level interactions (i.e., the *why*). A single holistic case study design permitted "exploration from multiple perspectives of the complexity... of a particular institution or system in a 'real life' context" (Simons, 2009, p.21).

Contextual conditions are highly relevant to the case study methodology. Accordingly, the unit of analysis (i.e., *case*) was bound in scope in the following ways: by *phenomenon* – inter-ministerial policy development as a *process* (or series of processes) between health and 'non-health' ministries; *setting*: Ontario's Ministry of Health and Long-Term Care (MOHLTC); *timeframe*: a 15-year period between 2003-2018; and *participants*: senior-level public servants as policy staff directly involved with policy development in 'real life' contexts.

3.9 Participant Eligibility

Purposive sampling was used as a method of non-random selection based on the qualities of the candidate participants (Tongco, 2007). As Christensen et al., (2020) note, long-term employees of a particular organization "are likely to have accrued a deep, insightful knowledge of its formal and informal norms and values across a wide spectrum" (p.70). Individuals were therefore eligible for participation if they were: 1) employed as a senior public servant within the MOHLTC between 2003-2018 (i.e., 'currently' or 'formerly' employed at the time of recruitment); 2) employed for at least one year; and 3) fluent English speakers.

3.9.1 Participant Recruitment and Sample

Eligible participants were contacted via their publicly available email addresses between March and May 2020. A total of 48 participants were provided with a scripted study invitation and a Letter of Information and Consent (Appendix A). One follow-up email was sent to those who did not respond within two weeks of initial contact. Those who agreed to participate signed and returned the consent form and indicated their preferred date and time for a phone interview.

Seven total participants were recruited, including two Senior Policy and Program Advisors, three Managers, and two Directors. Four participants were actively employed with the MOHLTC at the time of their interviews, whereas three were former employees. The average employment duration was approximately six years, with two employed for more than 10 years, two for five years, and three fewer than five years. All had worked in more than one division or branch of the MOHLTC, and one had been seconded to a ‘non-health’ ministry at the time of the interview.

3.10 Data Collection

3.10.1 Semi-Structured Interviews

Interviews were conducted via phone between March and May 2020, and ranged from one to two hours in length. Each interview was conducted using the same semi-structured interview guide (Appendix E), with questions asked in a pre-determined and consistent manner while also permitting a degree of additional conversation (Berg, 2007). The interviews were audio-recorded and supplemented with hand-written notes to track mention of important resources or initiatives, as well as additional questions for respondents based on the conversation at hand. Each interview was transcribed verbatim using Microsoft Word 2020, with accuracy ensured by listening to respective audio recordings during the initial coding process.

3.10.2 Policy and Process Documents

Resources at the ministry, Ontario Public Service (OPS), and broader government levels were collected to account for the *embeddedness* of path dependent conduct which may, in turn, shape government receptivity to procedural reform such as the introduction of HIA. Accordingly, documents were collected to fulfill four interrelated objectives, including to: 1) establish an overview of the MOHLTC’s policy purview between 2003-2018; 2) establish the province’s predominant approach to health promotion and protection over the 15-years of interest; 3) supplement and corroborate respondent accounts of the formal and informal mechanisms shaping inter-ministerial policy development; and 4) establish

a timeline of efforts to formalize a provincial framework for HiAP and related initiatives against the previous three objectives.

Participant feedback largely guided the collection of 77 publicly accessible documents to inform the above four objectives. Documents collected via the Ontario Government website included mandate letters (n=4), provincial budgets (n=15), throne speeches (n=8), “published plans” (n=13), Chief Medical Officer of Health reports (n=6), and ministry/OPS overviews (n=6). Moreover, key public health legislation (n=5), public health frameworks (n=2) and committee/taskforce reports (n=6) were collected via basic Google searches. Finally, a provincial HiAP timeline was additionally informed by Hansard Transcripts (n=9) retrieved from Ontario’s online Legislative Assembly archives, and position papers (N=3) from provincial public health organization websites. Basic keyword searches for “Health in All Policies” and “Health Impact Assessment” conducted via grey literature databases, including the *Our Digital World Ontario Government Document* portal, the *Ontario Legislative Library* and its *Government Document Collection* portal, and the *Canadian Public Policy Collection* portal, did not return relevant hits.

Finally, 10 instructional documents (e.g., policy standards, professional development guidelines) were retrieved via the *Policy Innovation Hub* – an in-house consulting branch of Ontario’s Cabinet Office. As these resources are generally intended for internal use among OPS employees, they were collected via phone and email correspondence with a branch manager.

3.11 Data Management and Analysis

Data were uploaded to NVivo 12 qualitative software for ‘theoretical’ thematic analysis guided by the integrated framework (Braun & Clarke, 2006). The initial coding structure was informed by the semi-structured interview guide which, upon its design, was divided into seven overarching components: 1) *ministry jurisdictions*; 2) *policy assessment*; 3) *harm prevention/mitigation*; 4) *policy alternatives*; 5) *evidence provision*; 6) *collaboration barriers & facilitators*; and 7) *HiAP/HIA initiatives*. Accordingly,

corresponding interview questions – each of which aligned with Bounded Rationality and/or Normative Institutionalism, were established as first order ‘parent codes’. Data were then organized, and themes identified, according to “some level of patterned response or meaning” (Braun & Clarke, 2006, p.82).

Whereas interview questions were useful in organizing the data based on their *semantic* (i.e., surface) qualities, *latent* analysis was undertaken to capture the nuance of corresponding data. This approach entailed a degree of interpretation in order to “identify underlying ideas, assumptions and conceptualizations that are theorized as shaping or informing the semantic data” (Braun & Clarke, 2006, p.84). The initial coding structure, and the core tenets of its underlying theoretical lenses as they unfolded ‘in practice’ were thus confirmed or refined through inductive analysis (Hsieh & Shannon, 2007). Descriptive codes were subsequently aggregated into higher-level categories and explored for possible relationships both within and between recurrent themes. The aim of this second phase was to establish a comprehensive understanding of the *how* and *why* of traditional inter-ministerial policy development. Both data collection and analysis were informed by a number of steps to ensure *trustworthiness* (Appendix C).

3.12 Ethics

Data collection commenced following approval from the Western University Non-Medical Research Ethics Board (NMREB) (ID: 113692) (Appendix D). The anonymity and confidentiality of all participants were ensured through the removal of personal identifiers from both the interview transcripts and the presentation of direct quotes within the findings manuscript. Moreover, all transcripts and NVivo files were password protected, and all study document stored on a secured private server.

3.13 Findings

3.13.1 The Predominant Foci of Ontario's MOHLTC between 2003-2018

Health System Services. In 2003, the First Ministers Health Accord identified *health care* as the top priority for governments across Canada. The First Ministers, including the Prime Minister and Premiers of Canada's 13 provincial and territorial governments, agreed upon a shared vision to "ensure publicly funded health services that provide quality health care and promote the health and wellbeing of Canadians" (Canadian Intergovernmental Conference Secretariat [CICS], 2003, p.1). To do so, a series of investment areas were identified, including: 1) primary health care; 2) home and community care; 3) community mental health; 4) medical diagnostic services; 5) health human resources; 6) pharmaceuticals, 7) service wait times; and 8) healthy living (CSIS, 2003). To assist sub-national governments in carrying out change efforts, the federal government committed to a multi-year increase in Canada Health Transfer (CHT) funding of approximately \$70 billion over eight years (Government of Canada, 2003). The agreement was subsequently renewed from 2004-2014, and again until 2024 (Bailey & Curry, 2011).

In Ontario, a range of "medically necessary" physician and hospital services are either fully or partially funded by the province through the Ontario Health Insurance Plan ("OHIP") (Closing the Gap Healthcare Group, 2018). As of 2020, these included visits to family doctors and specialists, basic emergency hospital stays, dental surgery in hospital settings, and abortion, ambulatory, optometry and podiatry services (Government of Ontario, 2021a). Per the Canada Health Act, the design and delivery of these services, which falls within provincial jurisdiction, must meet five criteria to receive full funding via the federal CHT (Government of Canada, 2017). The *public administration* criterion in particular assigns responsibility for the administration of the healthcare plan to Ontario's Ministry of Health and Long-Term Care (MOHLTC) as the "public authority accountable to the provincial government" (p.1). Moreover, *accessibility* requires reasonable access to healthcare services for all insured persons "without financial or other

barriers” (p.1). The remaining criteria include the *comprehensiveness* of insurance for medically necessary services, *universality* of terms and conditions for all insured persons, and *portability* of OHIP coverage (Government of Canada, 2017).

Ontario’s MOHLTC has traditionally overseen the strategic direction and operation of the province’s publicly funded health system. In 2003, the McGuinty government announced plans to initiate system-wide reforms, stating “the plan for health is anchored in a clear vision for health care” (MOHLTC, 2003, p.7). The Ministry’s major policy and performance priorities over the next 15 years were thus aligned with the eight investment areas identified through the First Ministers Health Accord, and the five criteria of the Canada Health Act. In 2006, for example, the government established 14 Local Health Integration Networks (LHINS) as regional entities responsible for the management, coordination and delivery of health care services deemed “fragmented, complex, and difficult to navigate” (MOHLTC, 2007, p.7). Services within the direct purview of the LHINs covered key priority areas of the MOHLTC, including acute and emergency health (e.g., public and private hospitals) and community and mental health services (e.g., mental health and addiction agencies and long-term care homes) (MOHLTC, 2007). This initiative allowed the MOHLTC to assume more of a stewardship role, with primary responsibility for the legislative landscape of the health system rather than the planning and delivery of healthcare services. Various other system-wide priorities spanned the McGuinty (2003-2013) and Wynne (2014-2018) governments, such as improving access to healthcare professionals and modernizing information infrastructure.

The Public Health Sector. Ministry staff interviewed for the present study agreed that the above policy purview has traditionally comprised the *health system services* realm of the MOHLTC. This and the *public health* system were viewed among participants as the Ministry’s two principal focus areas, and both were consistently listed as key priorities within the MOHLTC’s “annual published plans” between 2003-2018 (see MOHLTC, 2017). As such, Ontario’s public health system has typically been framed as *complementary* to the health care system: “public health contributes to reducing the need for other health care services by limiting the consequences of poor health, including, for

example, the need for acute medical care” (Stuart et al., 2009, p.3). Thus, whereas healthcare has largely been positioned as “consumer-centered” (e.g., 2002 Annual) and “patient-focused” (e.g., 2005 Annual), public health is said to function as its population-level counterpart, with a focus on primary, rather than predominantly secondary or tertiary, prevention (King, 2013; Lysyk, 2017). Together these two realms have shared “overlapping visions and goals” for health promotion and protection (Tamblyn & Hyndman, 2006, p.48).

The Health Promotion and Protection Act (HPPA, 1990) remains the primary legislation governing Ontario’s public health system. Section 7 of the HPPA authorizes the Minister of Health and Long-Term Care to set standards for the provision of mandatory public health programs and services within the broad thematic areas of: 1) health promotion and protection; 2) injury prevention; 3) family health; 4) communicable disease; 5) community sanitation; and 6) safe water systems (HPPA, 1990). Between 2003-2018, these were published as the Mandatory Health Programs and Services Guidelines (MHPSG, 1997) and the Ontario Public Health Standards (OPHS) (MOHLTC, 2008b; 2018b). As such, the Minister has traditionally set the broad strategic direction for public health through related legislation and standards.

Section 5 of the HPPA assigns responsibility to local boards of health for the provision of programs and services within the above thematic areas. Each board is led by a Medical Officer of Health, and functions as the governing body for a corresponding regional public health unit. The development, delivery, management and evaluation of public health programs and services therefore occurs at the community level to better respond to the needs of ‘health unit populations’ of various sizes and demographic compositions (Association of Local Public Health Agencies [alPHa], 2015). Boards of health are accountable to the MOHLTC for meeting the defined expectations within the OPHS (MOHLTC, 2018b).

The statutory basis of both the OPHS and the HPPA assigns clear primacy to a specified scope of health considerations and their corresponding promotion and protection mechanisms. This calls to attention some of the notable features of the upstream approach

espoused by Ontario’s public health sector (e.g., King, 2013). In particular, the stated goals of the OPHS seek to either a) create health enhancing environments (e.g., make ‘the healthier choice the easier choice’), or b) improve public awareness of, and capacity for, healthy lifestyles. Together these largely constitute a behavioural approach to health promotion and protection through which Ontarians must “play an active role in their health care by participating in healthy living and wellness” (MOHLTC, 2012a, p.7). For example, the School Health guideline within the 2018 OPHS seeks to improve the adoption of healthy lifestyles among school-aged children, youth and their families, noting “childhood is a time when health practices and behaviours are learned, and adolescence is a period when both positive behaviours (such as eating practices and physical activity) and risk behaviours (such as alcohol and substance use) are adopted” (MOHLTC, 2018b, p.5). Accordingly, boards of health are mandated to work with local school boards to design and implement health curricula and deliver health-related programs and services. In similar fashion, longstanding chronic disease prevention efforts targeting the population more broadly have centered on five modifiable risk factors, including poor diet, physical inactivity, tobacco use, alcohol misuse, and exposure to ultraviolet radiation (e.g., via tanning beds) (e.g., MOHLTC, 2008b; 2018b; King, 2013).

To ensure that programs and services are informed by evidence of both the health status and needs of communities, public health units must conduct *population health assessments* of trends in health behaviours, preventive practices, health care utilization, and demographics (MOHLTC, 2008b; 2018b). These assessments additionally involve the identification of ‘priority populations’ – i.e., those experiencing, or at increased risk of, poor health outcomes due to the burden of disease, the broader determinants of health, and/or their intersection (MOHLTC, 2018b). This requirement is aligned with a foundational *health equity* standard, which seeks to “*decrease* health inequities such that everyone has equal opportunities for optimal health” [italics added] (MOHLTC, 2018a, p.21). Both the population health assessment and health equity requirements therefore aim to ensure that public health practice is *responsive to* “current and evolving conditions” (p.18). Following their implementation, the health impacts of public health practices must be monitored by corresponding health units (MOHLTC, 2018a).

The provision of programs and services to address *specified health issues* on the basis of *population need* indicates that, from 2003-2018, Ontario’s predominant public health approach was to some extent conceptually aligned with the ‘*health improvement*’ component of a Health in All Policies (HiAP) strategy. Notably absent within the OPHS, however, has been an explicit requirement for the *proactive* assessment of programs and services. Together these key features have important implications for how far ‘upstream’ the public health sector (i.e., boards of health) has traditionally operated. In particular, both its scope and operational capacity have been largely defined by the parameters set by the MOHLTC. More importantly, however, it is the government ministries beyond the MOHLTC that have traditionally held near exclusive legislative and policy authority over the broader determinants of health (e.g., income, housing, education) (MOHLTC, 2019). As recently concluded by review of the MOHLTC, “the government has greater ability to influence certain health outcomes, and policies at the provincial level can sometimes result in even more significant changes than those at the local level” (Lysyk, 2017, p.545). From this broader perspective, the public health sector has therefore traditionally fulfilled a *midstream* approach to health promotion and protection. While there are clear benefits to tailoring healthy public policies according to community needs, boards of health possess little direct capacity to act further upstream – that is, to address the ‘causes-of-the-causes’.

3.13.2 Health in All Policies at the Provincial Level: Momentum and Inertia

There is some evidence of concrete efforts to formalize a provincial Health in All Policies (HiAP) strategy and related initiatives between 2003-2018. In this regard, only one interview participant noted HiAP to be a recurring agenda item “for a number of political parties” (H3). An electronic search was subsequently undertaken to identify instances in which “Health in All Policies” or “Health Impact Assessment” was discussed during Legislative Assembly (i.e., “House”) debates. Results indicated that neither of these terms was mentioned within the transcripts of the 1,350 sessions that took place over the 15 years of interest.

A second search was conducted to identify instances in which the above topics were discussed during House Committee sessions.³ Between 2003-2018, “Health Impact Assessment” was mentioned within three transcripts, both in relation to specific initiatives (e.g., wind turbines) and more passively (i.e., not as the main topic of discussion). On the other hand, “Health in All Policies” was discussed during six Standing Committee debates. Of note, three of these occasions entailed advocacy efforts by representatives of health organizations rather than MPPs. In particular, the Medical Officer of Health of the Peterborough County Health Unit, and both the Acting Director and the Chief Executive Officer of the Registered Nurses Association of Ontario (RNAO) each asked that an HiAP approach inform the 2014, 2017, and 2018 provincial budgets, respectively. Upon further exploration, however, it does not appear that these requests were explicitly incorporated into the official budget releases.

Similar advocacy efforts among provincial health organizations occurred during the 15 years of interest. In 2012, for example, a working group composed of members from two arm’s-length government agencies, Cancer Care Ontario (CCO) and Public Health Ontario (PHO), recommended that the government “explore legislation mandating health impact assessment for all provincial laws and regulations” (Cancer Care Ontario, 2012, p.4). In similar fashion, the Ontario Public Health Association (OPHA) called on all political parties to legislate a HiAP approach, including a required health impact component, as part of their election platforms (OPHA, 2014). Two years later, the OPHA asked the government to integrate HiAP legislation into health care reform efforts (OPHA, 2016).

Among government policy actors, Ontario’s former Chief Medical Officer of Health (CMoH) was a notable champion of HiAP and related initiatives. As a public servant reporting directly to the Deputy Minister of Health, the CMoH has traditionally fulfilled

³ Ontario government committees are small working groups of MPPs who consider Bills or specific initiatives on either an ad hoc basis (“Select” Committees) or for the duration of Parliament (“Standing” Committees).

an advisory and leadership role within the MOHLTC's Public Health Division. In 2009, the CMOH's Annual Report to the Legislature called for healthy public policy to "inform everything we do" (King, 2009, p.13), whereas the 2010 Report recommended that the government "start applying a health lens to every program and policy in Ontario at the provincial level" (King, 2010, p.7). Three years later, Ontario's seminal *Public Health Sector Strategic Plan* deemed public health to be "uniquely positioned" to bridge the MOHLTC with sectors responsible for the broader determinants of health, including education, housing, and income (King, 2013, p.2013).

HiAP-related initiatives appeared to gain some traction alongside the above advocacy efforts. In 2009, for example, the National Collaborating Centres for Public Health (NCCPH)⁴ reported that Ontario's Ministry of Health Promotion (MHP)⁴ planned to enhance its formal role in inter-ministerial policy development to support healthy public policies (d'Amour et al., 2009). These efforts were to be assisted by Public Health Ontario (PHO), which was established in 2008 to provide scientific and technical advice to assist MOHLTC priorities. PHO's primary legislation, the Ontario Agency for Health Protection and Promotion Act (OAHPP, 2008), remains a key framework for Ontario's public health system. Moreover, a number its requirements are relevant to healthy public policy and the use of impact assessment tools, including: *Object 6c*: "to inform and contribute to policy development processes... within the Government of Ontario through advice and impact analysis of public health issues"; *Object 6d*: "to undertake, promote and co-ordinate public health research in co-operation with academic and research experts as well as the community"; and *Object 6f*: "to provide education and professional development for public health professionals... and policymakers across sectors" (*Ontario Agency*, 2008, p.2).

⁴ The Ministry of Health Promotion (MHP) was established in 2005 as the first Ministry "devoted entirely to the promotion of both a healthy and active *lifestyle*" [*Italics added*] (MOHLTC, 2006, p.2). The MHP oversaw major provincial health promotion initiatives until it was amalgamated into the MOHLTC in 2011.

In 2010, a research team from the Centre for Research on Inner City Health (St. Michael's Hospital, Toronto, Ontario) contributed to a series of MOHLTC consultations to inform the development of an equity-oriented HiAP strategy. Specifically, the group developed a 'resource pack' including a compendium of intersectoral and HiAP-related research and grey literature, 16 HiAP case summaries, and a provincial economic impact assessment. The MOHLTC was also given a conceptual framework detailing the 'how' of HiAP implementation across international governments (Shankardass et al., 2011).

In 2012, a working group of members from the MOHLTC, PHO, and local Public Health Units developed a Health Equity Impact Assessment (HEIA) tool. Comprised of a template (MOHLTC, 2012b) and workbook (MOHLTC, 2012c), the HEIA was described as a decision support resource to enhance the equitable delivery of programs, services, and policies by embedding awareness of, and capacity for, equity-based decision making within organizations (MOHLTC, 2012b). Accordingly, it was intended for use within the healthcare system, among public health units, and by both health and 'non-health' government ministries. Two years later, PHO conducted multiple case studies of existing HEIA practices in Australia, New Zealand, United Kingdom and Canada. A final report, intended to inform the tool's use in Ontario, included key findings such as system and organizational barriers and facilitators of HEIA use (Tyler et al., 2014).

Despite the apparent momentum surrounding a formal HiAP strategy and related initiatives at the provincial level, these had yet to be implemented in a widespread and sustained manner by 2018. Most recently, Ontario's Auditor General concluded that the province had "no plan in place" with regards to "adopting an approach that requires policymaking to evaluate the impact on health" (Lysyk, 2017, p.544). In a 2018 follow-up session on the Auditor General's recommendations held by the Standing Committee on Public Accounts, Ontario's Deputy Minister of Health and CMoH both agreed that a formal HiAP strategy was "probably a work in progress" (Angus, 2018, p.63). This feedback reflected a general consensus among ministry employees interviewed for the present study. As a current Manager explained, "there isn't a standard health impact tool used, with the exception of the HEIA, which has had mixed uptake from what I've seen"

(H7). Similarly, a former Director noted, “there have been tools like the equity assessment that have been developed with, I would say, limited success” (H3), whereas another Manager felt HEIA use “should probably happen more than it does” (H2).

3.13.3 Policy Development between Health and ‘Non-Health’ Ministries

3.13.3.1 The Policy Purview of the MOHLTC: Organizational Structure & Shifting Priorities

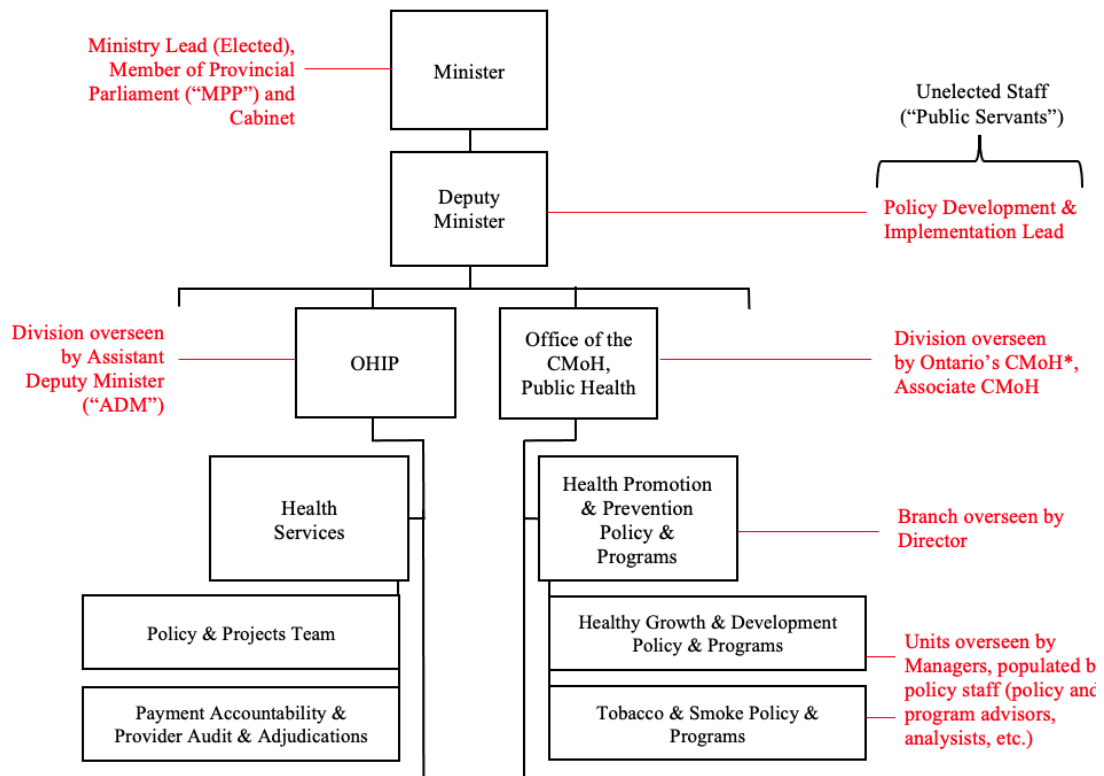
Participants generally indicated that the many divisions, branches and units of the MOHLTC have traditionally reflected its policy purview – that is, the ‘boundaries’ of attention, authority and policy and program action. As a current Manager explained, “the ministry has a robust organizational structure that fairly clearly articulates the ‘big’ files and topics that fall within its mandate. Divisions, branches and units are set up to support those priorities” (H7). Similarly, a current Senior Policy Advisor described organizational structures more generally as a means through which “everyone tries to stake out their territory”, noting further, “Ministries are divided such that the structure ensures there’s primary control and jurisdiction over certain policy areas” (H1). To illustrate, Figure 1 unpacks two divisions within the Ministry of Health⁵, calling to attention the hierarchical design of government ministries, and that which participants often referred to as the increasingly “granular” focus of branches and units.

Both the policy purview and organizational structure of the MOHLTC have been subject to ongoing and at times substantial changes. Accordingly, participants generally agreed that the ministry’s priorities have typically been responsive to real world events rather than fixed. As a current Senior Policy Advisor explained, “new needs can arise during the four years of any administration. Maybe they’re identified by external partners, for example, or they result from emerging health issues” (H4). A noteworthy example of this

⁵ The “MOHLTC” Health was split into two portfolios in 2019 – the “Ministry of” and the “Ministry of Long-Term Care”. Figure 1 is derived from a “Ministry of Health” organization chart as of February 2021.

latter point is the reforms to Ontario’s public health sector following two health crises – namely, a 2000 gastroenteritis outbreak in Walkerton, Ontario, and the 2003 Severe Acute Respiratory Syndrome (SARS) epidemic in Toronto.

Figure 1: Ministry of Health Composition, February 2021 (MOHLTC, 2021)



*Ministry Divisions have traditionally been led by ADMs with the exception of the Office of the CMoH

The province’s resultant *Operation Health Protection* (2004) framework established public health system renewal as a Ministry priority by highlighting the need for enhanced emergency management, health human resources, health system preparedness, and infection control (Tamblyn & Hyndman, 2006). Many of the reforms stemming from this initiative remain key drivers of Ontario’s public health approach, including a ‘modernized’ HPPA, the creation of PHO as an arm’s-length government agency, increased funding and operational capacity to local public health units, and the implementation of the 2008 OPHS.

Participants additionally indicated that, once established, the ‘big’ files of the MOHLTC also tend to evolve in a more incremental fashion. For example, a current Manager explained, “the [Medical Assistance in Dying] portfolio has had a lot of attention from the Federal government in terms of updating their legislation after recent court rulings, so the corresponding MOHLTC division has been responsible for updating the provincial component” (H2). The operational details of certain portfolios have also shifted following government turnover. For example, a second Manager highlighted the different responses to the Opioid crisis adopted by the Wynne (2014-2018) and Ford (2018) governments: “‘supervised consumption and injection sites’ are now ‘consumption treatment centres’... They were modified and scaled back to strike a balance between evidence and what the Ford government thought its constituents would support. (H7)

Finally, while participants generally agreed upon the broad health system purview of the MOHLTC, they expressed different views as to which of its component parts – that is, the aforementioned *health system services* or *public health* focus – has traditionally held precedence on the Ministry’s agenda. Some felt that public health has typically been underfunded and under-resourced. As one former Manager explained, “public health often works in the background – it’s invisible until something goes wrong. And in the meantime, we always said that it’s never as resourced as it should be” (H5). Similarly, a former Director noted, “when you’ve got limited resources and a growing budget, a lot of time and money is allocated to the cure or treatment-end of the spectrum rather than prevention” (H3).

3.13.3.2 Health Adjacent Initiatives and the SDoH

Participants agreed that policy and program initiatives are often shared among ministries. When asked about policy *jurisdictions*, for example, a former Director explained, “I wouldn’t use that particular language... one of the issues with health is that there’s no defining boundaries” (H6). Similarly, a current Manager noted:

The [MOHLTC] has typically funded homecare, for example, which includes services like ‘Meals on Wheels’ and shoveling driveways in the

winter. Those are sort of social facing rather than discrete health services. So, it's a blurry line to individually describe what the role of the [MOHLTC] is. (H2)

Similar to the “social facing” services within the MOHLTC’s purview, many participants also spoke of their frequent engagement with “social policy oriented” Ministries (H5) – namely, the Ministry of Education. Others described various degrees of involvement with “health adjacent” (H2) sectors, whose policy initiatives have typically had clear links to explicit health issues. For example, whereas one Manager described previous work with the Ministry of Finance in terms of tobacco tax revenue (H5), another explained, “the Ministry of Seniors and Accessibility have a lot of issues that have typically brushed up against ours, for example, how we’re supporting Ontarians with disabilities” (H2). Similarly, three respondents described frequent engagement with the Ministry of Long-Term Care after the MOHLTC was split into two portfolios (i.e., the Ministries of “Health” and “Long-Term Care”) in 2019. While “health adjacent” work was common among interview participants, many noted the nature and extent of inter-ministerial engagement to be contingent on where within the organizational structure ministry staff are situated. For example, a current Senior Policy Advisor stressed, “I think other people may answer differently... Like let’s say environmental policy and programs – there may be some connection with health. I haven’t worked with those, but I can see how others may have” (H4).

“Health adjacent” initiatives were generally understood as more proximal to the MOHLTC’s agenda than those with “more abstract” (H3) health implications. While many participants agreed that there has typically been an “acute awareness” (H6) of the SDoH among ministry staff, corresponding portfolios have traditionally belonged to ‘non-health’ ministries such as education or housing. Put simply by a current Manager, “I don’t think there have been instances where another ministry is developing a policy that should belong to us. In that case they’d just transfer the file” (H7). This understanding was consistent with that of other respondents, who further highlighted a clear division of labour among ministries. For example, a current Manager explained, “high-level inter-

ministerial conversations occur when new files emerge to determine which ministry will lead a cross-cutting issue” (H7). Similarly, a current Senior Policy Advisor described policy work to entail “narrowing down the process to a few select people who should be involved in order to filter out secondary considerations” (H1).

In light of the MOHLTC’s policy purview and the fluctuating health and “health adjacent” priorities therein, all participants agreed that responsibility for inter-ministerial coordination has traditionally belonged to whichever ministry ‘owns’ a policy file. Accordingly, ‘non-health’ ministries have largely been responsible for initiating efforts to prevent or mitigate potential negative health implications of their own policies. As one current Manager stated, “there’s no unit within our ministry tasked with reviewing another’s policy submission with a health lens. So, I think what you’re envisioning doesn’t exist” (H7). Similarly, a former Manager explained, “the ministry bringing the item forward would typically need to have that lightbulb moment” (H5), whereas a former Director noted, “unless they reach out, how would we know?” (H3).

3.13.4 Briefing Upward: The Brokering Function of the Bureaucratic Hierarchy

The government’s bureaucratic hierarchy was viewed as the key mechanism to integrate MOHLTC-relevant considerations into the development of non-health sector policies (Figure 2). As a current Manager explained, “this is literally the most hierarchical place imaginable [laughs]. I understand why, but it feels almost militaristic” (H7). Accordingly, participants generally described a formal and highly institutionalized “chain of command” (H2) through which health considerations *may* inform policy development in a systematic manner.

Public Servants. The Ontario Public Service (OPS) is comprised of non-partisan policy staff who work “on the ground” (H4) to develop, implement and evaluate government policies and programs. Given their political neutrality, policy staff (i.e., “public servants”) remain in place following government turnover. During this time, they fulfill policy-related duties in accordance with *The Public Service of Ontario Act* and the *Public*

Service Oath (Public Service of Ontario Act, 2006). For example, section 5 of the Act requires Ontario government employees to take an oath of confidentiality, stating, “*I will not disclose or give to any person any information or document that comes to my knowledge or possession by reason of my being a public servant*” (p.1). Elsewhere the eight stated values of the OPS notably include *collaboration* to build consensus and share responsibility (Government of Ontario, 2007b). Taken together, these formal institutions have traditionally guided OPS conduct and policy activity.

Policy staff are depicted by grey boxes within Figure 2. While participants noted that policy initiatives can arise in either a top-down (i.e., from the ‘political side’) or bottom-up (i.e., from the bureaucracy) manner, the hierarchical nature of each ministry was said to function as a “backstop to ensure connections are happening” (H3). As such, intra-ministerial policy decisions have traditionally been processed through a vertical “chain of command” (H2), with each subsequent level of approval informed by a broader purview of the issue at hand. As a current Manager explained, “when you’re lower down the rung you know your world really well, but you don’t know about the three other worlds occurring simultaneously. The more senior you are, the broader your perspective” (H2). Thus, participants generally highlighted the operational value of the bureaucratic hierarchy as a “brokering mechanism” (H7) to ensure policy development is informed by the necessary scope of perspectives and resources.

Participants considered *networking* with “on-the-ground” contacts (H1) to be vital to policy development. As a current Senior Policy Advisor explained, “oftentimes as you’re doing early thinking on something, you’ll do the informal reach outs to fill in some of the gaps and strengthen your proposal before you go for the formal approval” (H2). Figure 2 depicts the reported formal and informal communication between ministries using solid and dashed lines, respectively. In this regard, senior leadership was noted to “play a role in modelling the importance of cross-collaboration” (H7). For example, a former Manager deemed networking “really good policy work” (H5), whereas a former Director explained, “I always encouraged my staff to have their own network so that they could keep an ear on the ground across branches, and even Ministries” (H3). In a more formal

sense, resources such as the *OPS Competency Guide*, which outlines senior-level job performance indicators, specifies *networking* as a key competency involving “actively seeking opportunities to work horizontally, across traditional branch, division, and ministry boundaries” and “developing a basis for future interactions” (Cabinet Office, 2004a, p.19)

Finally, Assistant Deputy Ministers (“ADMs”) and Deputy Ministers (“DMs”) were noted to have formal venues such as respective “tables” through which inter-ministerial coordination has often occurred. As summarized by a current Manager, for example, “the Deputies from all the social policy ministries get together to review what they’re planning to bring forward so that by the time items get to Cabinet, no one is surprised” (H7).

Committees. A number of respondents highlighted *Policy Committees of Cabinet* as a key inter-ministerial component of the policy development process. The stated purpose of said committees is to “review and consider the merits and implications of ministries’ policy proposals” and “ensure coordination and promote alignment among ministries” (Cabinet Office, n.d., p.1). Two inter-ministerial committees have existed since 2016 – that is, “JEP” (Jobs and Economic Policy) and “HESP” (Health, Education, and Social Policy). The latter has typically provided reviews and recommendations to Cabinet regarding health-related proposals in areas such as health promotion, long-term care, and wellness. A former Director described committees as “a formal decision structure to ensure that Ministers are aware of items that are most likely to have an impact on their own portfolios” (H5).

Policy development has also traditionally been informed by Standing and Select Committees comprised of elected Members of Provincial Parliament (“MPPs”) from each political party. While Standing Committees oversee ongoing areas of legislative activity (e.g., education, health) for the duration of Parliament, Select Committees address specific bills or issues (Legislative Assembly of Ontario, n.d). In 2018, for example, the Standing Committee on Public Accounts convened to address the Auditor General’s 2017 review of the MOHLTC, which notably highlighted the province’s lack of a health

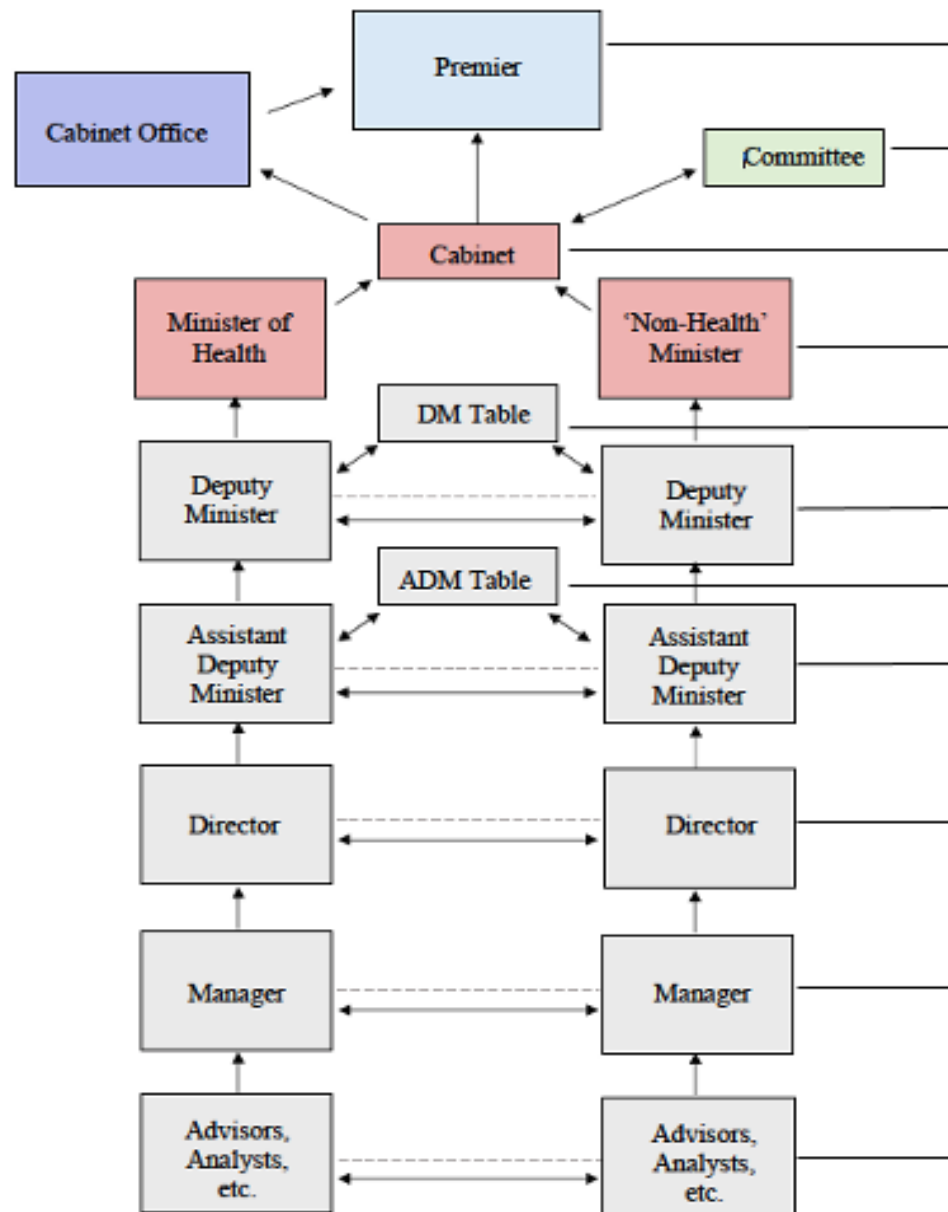
impact assessment approach (Lysyk, 2017). A series of Committee recommendations released through a 2019 report included “the [MOHLTC] should collaborate with other ministries to develop a Health in All Policies [HiAP] approach to assessing the public health impact of legislation and policy development” (Fife, 2019, p.15). Figure 2 depicts committees as adjunct structures engaged in two-way dialogue with policy officials, as they typically review Government Bills between their second and third readings (Legislative Assembly of Ontario, 2011).

Policy Officials. Figure 2 depicts elected policy officials, including Ministers and the Premier of Ontario, as blue and red boxes, respectively. These actors function on the “political side” (H3) of policymaking, and largely contribute to final decisions once a policy is “nearly fully baked” (H7). As Ministry leaders, Ministers are appointed by the Premier, who is the head of the provincial government. A former director explained, “Ministers need to sign off on the proposal before it can go to Cabinet. They need to achieve some degree of mutual agreement” (H6).

Participants highlighted Cabinet, comprised of Ministers of the governing party (i.e., the “Executive Council”), as a central decision-making venue. In particular, Cabinet members have traditionally introduced legislation for consideration in the Legislative Assembly – a process often accompanied by a brief presentation by the sponsoring Minister, and review of the recommendations made by corresponding committees (Davidson, 2016). The OPS is then responsible for implementing the final policy directions decided upon by Cabinet. As noted, however, such decisions may also guide policy development in more of a top-down manner.

Interview participants highlighted two additional mechanisms through which policy may be shaped. First, the Cabinet Office has traditionally supported the Premier and Cabinet through the provision of policy-related advice and analysis (Government of Ontario, 2012). A current Manager described its mandate to include “reviewing and writing briefing notes with analysis on every Cabinet submission and ensuring that there is identification of linkages across Ministries and policies” (H2). Given its coordinative function, Cabinet Office is situated above the other Ministries in Figure 2.

Figure 2: Visual Depiction of Intra- and Inter-Ministerial Policy Development



Policy work happening at the political level may entail a certain approach that is quite different from what would come out of the bureaucracy. – Former Director (H3)

Committees take an all-government look at various policy approvals that come through, and then afterward it goes back to Cabinet for subsequent readings. It's a fail-safe structure. – Former Manager (H5)

All Cabinet Ministers review and approve all policy and legislative items. So, once it goes through the policy committee, it goes to Cabinet for formal review. – Former Director (H6)

If the Minister isn't comfortable with it, they're not going to bring it forward to Cabinet if they don't think it's a good idea. So, they pretty much have the final word. – Current Manager (H7)

DMs have a tight network between them, and they work to come to an agreement on a proposal... They'll have a different lens than the politicians, but they typically work to align their outputs with political interests as best they can. – Current Manager (H2)

I think there's a reputational component in that ADM networks exist. As soon as someone says 'mental health and addictions' people automatically think of the ADM who's doing that work. So, it becomes like a knee jerk reaction to set up those tables. – Former Manager (H5)

My previous director was always prompting us as staff to think about who else we should be running things by, and what areas might be able to provide helpful advice. – Current Senior Policy Advisor (H4)

You're expected to touch base with your higher ups. Usually if I'm unsure of what I'm proposing, I'll talk to my manager and he'll talk to the Director to gauge more strategically how certain personalities will respond. – Current Senior Policy Advisor (H1)

It's expected the policy is not developed in a vacuum. Senior-decision makers rely on public service staff to be talking to each other, making linkages, providing advice to each other, etc. – Current Manager (H7)

final source of policy influence may include the Official Opposition.⁶ In particular, the *shadow cabinet* is comprised of “critics” tasked with “scrutinizing the activities and policies of ministries, and questioning Cabinet Ministers during [Legislative Assembly] sessions” (Legislative Assembly of Ontario, n.d). While the official opposition has not traditionally held decision-making authority, Cabinet is accountable to the Legislative Assembly for delivering on government priorities.

3.13.5 The Nature of Inter-Ministerial Policy Work: Shared Mandates, Advice, and Approvals

Participants emphasized the markedly intersectoral nature of policy development across the Ontario government, and generally agreed upon growing expectations for boundary-spanning work. Accordingly, a current Manager felt those outside of government “would be shocked at the number of people involved in the policy process” (H2). Of note, however, the above “brokering structure” has not traditionally functioned as a means to systematically identify and address the potential negative health impacts of ‘non-health’ sector policies. Rather, participants tended to highlight the utility of the bureaucratic hierarchy in terms of fulfilling health and “health adjacent” initiatives – namely, *service coordination* and *program delivery* (H2). As such, a Senior Policy Advisor described inter-ministerial policy development to entail “soliciting advice and perspectives from all relevant sectors, and having them speak to their specific area” (H4).

The government’s approach to boundary-spanning work appears to be reflective of and reinforced by certain formal institutions both within and beyond specific ministries. For example, in a 2014 mandate letter to the Minister of Health and Long-Term Care, Premier Wynne tasked the Ministry lead with “promoting healthier lifestyles for Ontarians through shared responsibility across government” (Wynne, 2014, p.2). To do so, a number of “health adjacent” priorities were highlighted. For example, the MOHLTC

⁶ The Official Opposition is the political party with the second-greatest number of elected candidates after the governing party.

was instructed to engage with the Ministries of Education, and Municipal Affairs and Housing, to support the province's *Community Hubs* initiative which, since 2015, has repurposed surplus public buildings (e.g., public schools) according to community needs (e.g., social service, childcare, or recreation centres). Many participants also called to attention the ways in which more proximal *senior leadership* may both enable and constrain inter-ministerial engagement. As a former Director noted, "it really depends on who you have at the political level, within the ministry, within Cabinet Office... All those people's management styles are important" (H3).

In similar fashion, a Senior Policy Advisor explained, "government is an odd mix between very strong personalities and very fossilized bureaucratic structures. This combination really determines how things move forward" (H1). In this regard, inter-ministerial policy development is also notably reflective of the required components of Cabinet Submissions – that is, "the main tool that government uses to evaluate options and recommendations to arrive at a decision on a policy issue" (Cabinet Office, 2004b, p.6). A current Manager described the Cabinet submission as "a template that provides the base level information [we] need to be considering and providing. It has a lot of really solid prompts in terms of what we should do" (H7). For example, policy staff have traditionally been required to document both formal and informal engagements across government, and the ways in which a proposed policy may impact the operational priorities of other ministries. Moreover, while *financial, government, economic, and business sector* impact assessments are to inform the development of policy proposals, where appropriate, health impact assessment are not a required component of the Cabinet Submission.

In light of the government's traditional approach to inter-ministerial policy development, participants indicated that there have been instances in which corresponding areas of the MOHLTC have provided *advice* (H5), *input* (H4), or *recommendations* (H3) regarding the potential health implications of non-health sector policies. Given the confidential nature of much of the policy process, however, such advice or input is typically provided in a reactive manner. Moreover, whether said information actually informs policy

development has remained at the discretion of senior leadership. As one former Director explained, “we would pretty much know from early conversations whether [our recommendations] were going to be accepted or not. We would talk about positioning, and they would be quite frank about the political direction they’d received” (H3). A second former Director similarly noted, “it would be unlikely that new information would come out through the involvement of the [MOHLTC] that would significantly change the proposal” (H6). This feedback was of notable contrast to that that regarding more “health adjacent” initiatives, where participants generally agreed “other ministries can’t really move toward implementation unless they have the relevant [MOHLTC] approvals” (H4).

Taken together, Ontario’s approach to inter-ministerial policy development was largely viewed by participants to be highly functional given the “realities” (H4) of policymaking. As a current Manager explained, “you can tie yourself into knots trying to create the perfect policy, but perfection is often the enemy of the good” (H7). Similarly, a former Director concluded, “I would challenge someone to actually come up with a better way of doing this” (H6).

3.14 Discussion

The HIA literature offers few insights into the facilitators of and/or barriers to the initial implementation of HIA in government settings. Instead, much of this work focuses on strategies to foster the ongoing use of HIA across a range of contexts and, in so doing, often conflates ‘institutionalization’ with ‘implementation’. While both processes undoubtedly benefit from shared mechanisms and strategies (e.g., legislation, political will), Ontario’s experience demonstrates that the cart cannot come before the horse. Momentum surrounding HiAP and related initiatives entails multiple moving parts and, perhaps for this reason, said initiatives may fall from the government’s agenda before coming to fruition. In similar fashion, implementation appears to necessitate a confluence of complex factors and, where this occurs, institutionalization (i.e., sustained use) is not guaranteed. Ontario’s lack of HIA adoption to date has thus provided a valuable opportunity to take a step back and examine the government context against which momentum has waxed and waned. Findings from the present study contribute to the

existing literature on HIA use and, more specifically, the facilitators of and barriers to initial HIA implementation. The following discussion revisits these findings and further identifies possible points of entry for HIA within Ontario's policy arena. These insights may extend to comparable government settings within sub-national jurisdictions.

The MOHLTC has in some instances been identified as the anticipated steward of a provincial HIA approach (e.g., d'Amour et al., 2009; King, 2013; Lysyk, 2017). The overview of the Ministry's policy purview from 2003-2018 illustrates the backdrop against which such efforts have occurred. In particular, as the two predominant focus areas agreed upon by participants, both *health system services* and the *public health sector* have been firmly rooted in a number of longstanding legislative frameworks. From a normative institutionalist perspective, such frameworks constitute 'formal' institutions in that they are "consciously designed and clearly specified" (Lowndes, 1996, p.182) and "increase capability by reducing comprehensiveness" (March & Olsen, 1989, p.17). Put simply, they function to allocate both individual and Ministry attention by specifying policy priorities and target outcomes. In so doing, legislation functions to both explicitly and implicitly embed shared values, beliefs, norms, and routines (Sending, 2002).

While public health has been deemed "uniquely positioned" to bridge health and 'non-health' government ministries to foster a more integrated policy approach (King, 2013, p.2), both the Health Protection and Promotion Act (HPPA) and Ontario Public Health Standards (OPHS) appear to have important HIA-related implications. For example, where HIA has been implemented, governments have recognized the broad social, environmental, economic and physical determinants of health, and thus the widespread impacts of public policies beyond traditional health sectors (e.g., Banken, 2001; Signal et al., 2006; Walpita & Green, 2020). This constitutes a "new public health" approach, according to which governments seek to create health enhancing environments, and recognize that "everything they do or fail to do affects the population's health and wellbeing" (Bernier, 2006, p.23). While Ontario's public health sector is positioned as *complementary to* the healthcare realm, its stated upstream and population-level focus has traditionally prioritized a behavioural health promotion approach. As such, there is a

clear onus of responsibility on individuals to become better informed of strategies to maintain or improve their own health, adopt healthy lifestyles, and avoid unhealthy or ‘risk’ behaviour. This is perhaps best exemplified by the province’s longstanding efforts to target modifiable chronic disease risk factors, including poor diet, physical inactivity, tobacco use, alcohol misuse, and exposure to ultraviolet radiation. Each has constituted a priority area within the 2008 and 2018 iterations of the OPHS, as well as their 1997 predecessor. Moreover, the HPPA articulates explicit priority areas for boards of health, including infectious and non-communicable disease, injury prevention, tobacco use, and dental and nutrition services. The statutory basis of the OPHS and the HPPA have thus functioned to a) allocate ministry attention toward explicit health issues; b) employ a largely downstream approach to ameliorating health disparities, while simultaneously encouraging individuals to prevent the future onset of illness or disease; and c) prioritize programs and services as a means of correcting ‘unhealthy’ public policy.

Rather than diminishing the demonstrated benefits of this approach, it is important to highlight the tendency toward *lifestyle drift* that Ontario’s public health legislation has seemingly embedded. Moreover, while both regional boards of health and the provincial government have cultivated health enhancing environments, for example through longstanding initiatives such as Smoke Free Ontario (2006) (Sudbury Public Health, 2021) and Healthy Food for Healthy Schools (2008) (Ministry of Education, 2018), the province’s predominant focus on explicit health issues has aligned these efforts with the *health improvement* rather than *impact mitigation* component of a HiAP strategy.

To foster healthy public policy through HIA necessitates broadening attention to non-health ministries and their policy objectives, as it is these rather than the MOHLTC or regional public health units that have traditionally overseen the design and implementation of upstream health determinants – that is, the ‘causes of the causes’. Although respondents perceived a widespread understanding and recognition of the determinants of health throughout the MOHLTC, their stated roles and responsibilities as policy staff appeared to be reflective of and reinforced by the above legislative frameworks. Accordingly, many spoke of the Ministry’s policy objectives as if along a

spectrum, with some considered more proximate to the MOHLTC's core agenda than "health adjacent" or "social policy" initiatives. While still relevant, the latter have traditionally constituted shared portfolios across ministries. As such, respondents tended to highlight the potential health implications of social policy areas such as Education, which has long been prioritized within the OPHS. Other policy areas such as Finance were considered to entail "more abstract" health implications, and thus less relevant, if at all, to health's core agenda.

The above insights are also consistent with formal institutions beyond the MOHLTC. In particular, Policy Committees of Cabinet such as *Jobs and Economic Policy* (JEP) and *Health, Education and Social Policy* (HESP) are clearly indicative of more widely embedded perceptions of proximate or overlapping policy portfolios. From an operational standpoint, such institutions prescribe the typical scope of inter-ministerial policy development and, as such, further call into question the extent to which the Ontario government has traditionally embraced a broader determinants of health approach (Banken, 2001; Signal et al., 2006; Walpita & Green, 2020). As the policy priorities of non-health and, in particular, economically-oriented sectors have been less receptive to HIA internationally (Berensson & Tillgren, 2017; Gagnon, 2008; Manhiemer et al., 2007; Mattig, 2015; Knutsson & Linell, 2010), it is critical to consider how such institutions may reinforce perceptions of health 'proximity' both within and beyond the MOHLTC (see also Lavis et al., 2003). This is especially so if health actors are not only expected to adopt HIA, but also exert influence and promote its use across various government sectors (Put et al., 2020).

Legislation is widely highlighted as a useful HIA lever, perhaps most notably within Ontario's neighbouring province of Québec (Bernier, 2006; Boldo et al., 2011; Diallo & Freeman, 2020; Gagnon, 2008). In light of the significant legislative basis of Ontario's public health sector to date, it would be reasonable to explore this mechanism as a possible entry point for HIA. Given the regional focus of Ontario's traditional public health approach, however, amendments to existing frameworks such as the OPHS would not be appropriate for a government-level HIA strategy. Moreover, as the above

discussion suggests, a future mandate should extend beyond the MOHLTC itself to cultivate a widespread ethos of healthy public policy (Boldo et al., 2011; Breeze & Hall, 2002; Delany et al., 2014; Kearns & Pursell, 2010). In this regard, it is critical to consider the time and extent of cultural and administrative reform that HIA legislation may require. This is especially so since legislation alone may not ensure HIA use (Harris & Spickett, 2011; Lee et al., 2013; O'Mullane, 2014) or the actual integration of health considerations into non-health policy decisions (Boldo et al., 2011; Gagnon, 2008).

Receptivity to proposed reforms may depend in part on the perceived functionalism afforded by existing arrangements (Christensen, 2020). It is thus notable that respondents very clearly agreed upon the operational utility of the bureaucratic hierarchy. These sentiments extended to the traditional division of labour both within and beyond the MOHLTC, which was said to accommodate the “realities” of policy development – namely, limited time and budgetary resources. Future HIA implementation efforts should therefore be mindful of the likely ‘cultural compatibility’ of proposed changes to existing institutions – that is, norms, values, and routines (Carey et al., 2017; Christensen et al., 2020; O'Flynn et al., 2010). For example, it is clear that collaboration is valued across government, whether via informal networking “on the ground” or through more formalized bureaucratic approval processes. However, the MOHTLC’s inter-ministerial priorities to date have predominantly centered on program coordination and service delivery rather than a systematic *impact mitigation* approach. In this regard, respondents did not feel that application of a ‘health lens’ to non-health ministry policies has traditionally been within the capacity or purview of the MOHLTC. Instead, the bureaucratic hierarchy was widely viewed as the key “brokering mechanism” through which impact mitigation *may* occur. As this perceived functionalism may hinder HIA implementation efforts (Kearns & Pursell, 2010; Knutsson & Linell, 2010; O'Mullane, 2014; Signal et al., 2006) the question then becomes, how can proponents convince policy actors of the value of change where there is a sincere belief that existing norms, values, and routines (i.e., institutions) are sufficient?

Prospective HIA legislation should be accompanied by efforts to cultivate a culture of collaboration driven by widespread recognition and systematic action on the broad, upstream determinants of health (Delany et al., 2014; Kearns & Pursell, 2010). The relative permanence of public servants compared to their political counterparts suggests that such efforts should target the policy staff level where collaboration is already clearly valued. For example, both current and former Managers and Directors indicated that they often encouraged their staff to partake in both intra- and inter-ministerial networking, as this was generally agreed to constitute “good policy work”. Others indicated that the nature and extent of more formal collaborative efforts was typically established by those even higher up – namely, Assistant Deputy Ministers. As policy staff often seek to move up the ranks throughout their public service careers, early efforts to foster an environment conducive to healthy public policy may therefore benefit from both top-down and bottom-up diffusion (e.g., Byambaa et al., 2014). However, this proposed strategy may be hindered by the embedded nature of existing institutions (Kearns & Pursell, 2010; Knutsson & Linell, 2010; Signal et al., 2006) which are, by definition, relatively resistant to change (March & Olsen, 1989). The time and engagement required for such cultural change suggests that this strategy is perhaps better suited as an institutionalization strategy (Berensson & Tillgren, 2017; Knutsson & Linell, 2010; O’Mullane, 2014).

Initial HIA implementation instead appears to depend significantly on high-level champions and buy-in both within the health sector and across government more broadly (Delany et al., 2014; Harris & Spickett, 2011; Lee et al., 2013). With a few notable exceptions, this facilitative mechanism appears to have been critically absent from the momentum surrounding HIA between 2003-2018. However, advocacy efforts have typically been communicated through reports to the Legislature or, in the case of public health organizations, via recommendations to inform government budgets or election platforms. While commendable, the passive and often last-minute nature of such strategies has arguably left little room to convince non-health sectors as to *why* they should integrate health considerations into their policy decisions (Boldo et al., 2010; Carey et al., 2014). In this regard, a *win-win* approach (Molnar et al., 2016) may require considerably more time and strategic forethought than, for example, organization position

statements. Moreover, future buy-in should be sought at the highest possible level of policy official. As interview respondents indicated, it is the Ministers and Premier who are ultimately responsible for the strategic direction of government. Advocacy efforts may therefore enhance the perceived value of HIA if pitched in a way that both aligns with and furthers the political agenda of the government of the day (Delany et al., 2014).

In light of the inevitability of government turnover, future advocacy efforts would additionally seek to identify existing institutionalized structures and processes into which HIA may be integrated (Banken, 2001; Bernier, 2006; Lee et al., 2017). As an arm's length organization, PHO is arguably well-equipped to develop and pilot HIA methodology, facilitate training among public servants, and provide the necessary technical and resource support for initial implementation and sustained use (Kearns & Pursell, 2010; Lee et al., 2013; Signal et al., 2006). Similarly, as a systematic and widely utilized policy tool, the Cabinet Submission was reported to have a direct impact on the daily conduct of interview respondents. Once validated, HIA may be integrated into this policy tool alongside existing requirements for inter-ministerial policy development, including financial, government, economic, and business sector impact assessments (Banken, 2001). Over time, this avenue may function as a key means of demonstrating and embedding the value of HIA among policy staff and officials alike.

A number of opportunities for future research exist. To begin, HIA proponents would arguably benefit from the development of enhanced win-win strategies as a means of securing high-level buy-in among policy officials. Both the HIA literature and findings from the present study suggest that such strategies should be tailored according to the perceived 'proximity' of policy realms – that is, whether seeking integrated policy development between health and “social” versus “economically oriented” government ministries. Moreover, as much of the existing literature centers on the experiences of those who conduct HIA “on the ground”, there appears to be little insight into the political mechanisms that may facilitate and/or impede its initial implementation. Future research may therefore explore the perspectives of policy officials, as they have been theorized to adhere to different decision criteria than their non-partisan counterparts (e.g.,

Egeberg 2003; Newman et al., 2015; Peters, 2015). These insights appear especially pertinent to HIA implementation given the apparent benefits of high-level champions. Finally, a significant body of research has examined the use of HIA in Québec, and Health Lens Analysis in South Australia. Researchers are encouraged to follow this trend within their own jurisdictions of interest so as to further enrich the evidence base with detailed and nuanced understandings of HIA implementation and institutionalization within government contexts.

3.15 Study Limitations

Case study findings are often considered limited in terms of their generalizability across contexts. However, the norms, values, and routines that shape policy actor conduct are theorized as organization-specific (March & Olsen, 1989). Similarly, both the methodological design and implementation of HIA are highly contextual (McCallum et al., 2015). As such, strategies pertaining to its use should be tailored to specific administrative arrangements and culture rather than rely on the “elusive goal of finding ‘exemplary models’” (Bernier, 2006, p.35). Nonetheless, the present study was guided by an integrated framework informed by two complementary theories deemed highly germane to the study of bureaucratic policymaking (Peters, 2015). Such frameworks permit findings to be compared across bodies of work that have utilized these or similar theoretical lenses (Miles & Huberman, 2005; Yin, 2009).

In recruiting former Ministry of Health staff, the potential issue of selective recall should be noted. The sample of seven participants is also a limiting factor. Recruitment was initiated at the outset of the COVID-19 pandemic, at which time Ontario announced a state of emergency. This in turn significantly impacted the ability and willingness of Ministry of Health staff to participate in the present study. However, participants included both current and former senior-level policy staff, all of whom had been immersed within the organizational culture of interest for at least three years. Their insights were also supplemented with a range of documents and frameworks spanning the 15-year period of interest, thereby enhancing the credibility of the findings.

3.16 Conclusion

The present study explored the traditional nature of inter-ministerial policy development between Ontario's health and 'non-health' ministries. In so doing, it has shed light on the government context against which HIA momentum has both increased and stagnated between 2003-2018. Considerations of the barriers to, and possible facilitators of, HIA implementation should inform future efforts. Most importantly, HIA proponents must identify high-level champions of this decision support tool, as buy-in among top policy officials appears to have been critically absent from previous advocacy efforts.

Accordingly, the potential value of HIA should be demonstrated through, for example, tailored win-win strategies. Considerable time, effort, and engagement are also needed to generate HIA understanding, capacity, and confidence among policy staff. As this will likely necessitate some degree of cultural and administrative reform, buy-in may be enhanced where HIA can be integrated into existing institutionalized structures and processes. In this regard, primacy should be given to expanding Public Health Ontario's existing technical and resource support mandates, while at the same time introducing HIA alongside the range of impact assessments already required for Cabinet Submissions. More generally, these findings demonstrate that government organizations are indeed bound by their respective norms, values, and routines. While these have clear benefits in terms of intra-ministerial policy objectives, they may also critically impede the broader boundary-spanning purview necessary to identify and mitigate the potential negative health impacts of non-health sector policies.

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Chapter 3

4 Political factors surrounding the institutionalization of health impact tools in Québec and South Australia: A synthesis of “lessons learned” for emulator regions.

The public policies of ‘non-health’ government sectors have greater impacts on population health than those of health departments or the traditional healthcare realm (de Leeuw & Clavier, 2011). The policy and program objectives of said sectors give them de facto control over a range of social determinants of health (SDoH) including, but not limited to, education, employment and working conditions, housing, and food security (Raphael, 2016). As the ‘conditions of daily life’ (World Health Organization [WHO], 2008, p.26), the SDoH function as the mainsprings of health in that their upstream distribution shapes more downstream behavioural (e.g., lifestyle) and biomedical (e.g., access to care) health determinants (Wolf & Braveman, 2011).

While public policies themselves are critical determinants of health (Clavier & de Leeuw, 2014), their design and implementation are largely contingent upon political factors situated even further upstream (Bambra et al., 2005; Mishori, 2019). Dawes (2020) describes these factors as the ‘determinants of the determinants’, arguing that health outcomes can be traced back to politics even when they “are deemed to result from environmental, social, economic, healthcare or behavioural” factors (p.32). Similarly, Solar and Irwin (2010) note the ‘structural’ determinants of health to include the socioeconomic-political contexts that shape various ‘intermediate’ SDoH, including material and psychosocial circumstances within societies. The authors’ *Commission on the Social Determinants of Health* framework emphasizes the health inequities stemming from the unequal distribution of the SDoH, thereby attributing differential health outcomes, at least in part, to political contexts and circumstances.

The inherently political nature of policy and, by extension, *health* has long been agreed upon (de Leeuw & Clavier, 2011; Kickbusch, 2015). What is ‘political’ about either, however, appears to span a range of issues, including processes of conflict, cooperation,

and negotiation; conceptualizations of evidence and its use; the roles of power, institutions, ideology, and values; and relationships between public and private actors and stakeholders (Dawes, 2020; Kickbusch, 2015; Parkhurst, 2017; Raphael, 2015). Related efforts have sought to collate these and other politically-oriented foci as they relate to policymaking generally (e.g., Smith & Katikireddi, 2012), and health, in particular (e.g., Bambra et al., 2007). Put succinctly by Bambra and colleagues, “policy is formulated within certain pre-set political parameters which define what is, and what is not, possible or acceptable” (Bambra et al., 2005, p.5).

In light of the significant population health impact of ‘non-health’ sector policies, Health in All Policies (HiAP) has gained international prominence as a strategy to promote action on the SDoH: “*HiAP is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity*” (WHO, 2014, p.1). Efforts to integrate health considerations into ‘non-health’ sector policies demonstrate the political complexity of policy development. For example, each sector operates according to its own objectives and priorities and, as such, is typically inclined to view policy issues according to its own distinct ‘lens’ (Gagnon et al., 2008; Lawless et al., 2018). Accordingly, health outcomes may be considered peripheral to specific priorities, if at all relevant (WHO, 2014). HiAP is thus a necessarily political rather than technocratic policy approach involving ongoing negotiation, cooperation, and coordination among various interests (Kokkinen et al., 2017).

One means of placing health onto the agenda of ‘non-health’ government sectors is through health impact assessment (HIA) – a decision support tool designed to identify and promote the health benefits of policies, as well as mitigate their potential negative impacts. HIA may be conducted with or without a broader HiAP framework in place, and is considered a highly structured approach to integrating health considerations into public policies (St-Pierre, 2009). Moreover, like HiAP, the inherently political nature of HIA is widely noted (e.g., Kemm, 2001; Scott-Samuel et al., 2001). As Bekkers (2007) contends, “HIA is like walking on a tightrope: negotiating the balance between different

stakeholders, uncertainties in knowledge and expectations, scientific knowledge and political imperatives, and professional values and administrative behaviour” (p.39). Nevertheless, it has attained a degree of institutionalization among both national and sub-national governments internationally (Linzalone et al., 2018).

Apart from Québec, HIA has yet to be implemented by provincial governments across Canada, despite numerous calls to do so over the last decade (e.g., King, 2010; Ontario Public Health Association, 2015; Lysyk, 2019). In Ontario, a Health Equity Impact Assessment (HEIA) tool was developed by the Ministry of Health and Long-Term Care (MOHLTC) for use within and beyond the healthcare realm (MOHLTC, 2012). However, there is little evidence to date of its systematic uptake at the provincial level. As such, there remains significant potential to enhance provincial efforts to both promote and protect population health. **The present study therefore sought to explore the conditions sufficient for the adoption and sustained implementation of HIA at the sub-national (e.g., provincial, state) government level.** To do so, Québec and South Australia were selected as exemplary jurisdictions in which impact assessment tools have been institutionalized – that is, wherein a “permanent demand” (Banken, 2001) exists. As the adoption of HIA and related strategies like HiAP is considered a political undertaking, specific focus was given to the political factors that have contributed to both its initial and ongoing use. A framework analysis was conducted to identify the factors unique to and shared by both regions, such that the findings may serve as a useful blueprint for HIA proponents operating within similar sub-national government contexts (Druet et al., 2011).

4.1 Tools to Assess the Health Impacts of Public Policies

HIA is commonly described as “a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects” (WHO, 1999, p.1). Québec’s HIA approach is consistent with this conceptualization and, per the province’s Public Health Act (2002), assessments are to be conducted on proposed legislation and regulations

(d'Amour et al., 2009). As such, the application of HIA in Québec may entail five structured steps: 1) Screening proposals for potential impacts on the state of health or its determinants; 2) Scoping and Summary Analysis of the source, nature, and magnitude of possible impacts, as well as population subsets likely to be affected; 3) In-Depth Analysis to specify health impacts and potential mitigation strategies; 4) Adjustments to account for possible negative health impacts of proposals and ensure informed decision making; and 5) Process Evaluation and Follow up to improve the quality and long-term relevance of HIA, and establish indicators to trace potential health impacts (Hamel et al., 2006). South Australia's Health Lens Analysis (HLA) tool builds on the HIA methodology while also incorporating a range of additional analytical techniques (e.g., economic modelling), where required (Buckett et al., 2011). Unlike Québec's approach, the HLA has been implemented as part of a broader HiAP framework. Moreover, it is typically undertaken as early as possible in the policy process, whereas HIA is applied to draft laws or regulations (Quigley, 2010). Notably, both are based on the understanding that the most effective levers for improving population health are situated beyond the healthcare realm (Druet et al., 2010). Like HIA, HLA entails five steps: 1) Engage in collaborative relationships with partner agencies; 2) Gather evidence to establish links between policies and health outcomes, and identify evidence-based options; 3) Generate policy recommendations; 4) Navigate recommendations through governance and decision-making structures; and 5) Evaluate the HLA's effectiveness (Buckett et al., 2011).

As noted, Québec remains the only Canadian region in which HIA has been implemented at the provincial level. While other provinces, including British Columbia and Ontario, have demonstrated notable interest (Banken, 2001; Lysyk, 2019), respective efforts to keep HIA on the government agenda have stagnated. These outcomes appear to reflect trends at the national level. In the late 1990s, for example, Health Canada released *The Canadian Handbook on Health Impact Assessment* amidst growing interest in HIA. After two subsequent volumes, however, the handbook was permanently archived in 2013 (McCallum et al., 2015). Most recently, the enactment of the Impact Assessment Act

(2019) broadened the scope of health considerations required to inform federally-mandated environmental impact assessments. Whereas these previously entailed a narrow focus on biomedical health determinants (McCallum et al., 2015), they now include considerations of potential impacts on the SDoH and Indigenous health (Freeman, 2019). While these efforts highlight notable progress at the federal level, Canada's provincial and territorial governments possess significant policy and legislative authority over key SDoH (Howlett & Newman, 2010). It is thus critical to better understand the factors conducive to the adoption and sustained implementation of HIA at the sub-national level.

4.2 Policy Transfer: “who learns what from whom?”

The design and application of health impact tools are highly context-specific (McCallum et al., 2015), depending in part on both past and present political circumstances (Kickbusch & Buckett, 2010). As Rose (1993) remarks, “policymakers are inheritors before they are choosers ... new programs cannot be constructed on green field sites; they must be introduced into a policy environment dense with past commitments” (p.78). Nevertheless, efforts to institutionalize HIA in one region may be informed by prospective evaluations of the experiences of others (Linzalone et al., 2018), particularly where assessment tools have been implemented for at least ten years, thereby making subsequent outcomes more apparent (Smits et al., 2015).

Both HiAP and HIA have attained a degree of international prominence, with the former implemented in 16 countries as of 2014 (Baum et al., 2014), and the latter in 20 as of 2018 (Linzalone, 2018). As impact assessment tools have been sustainably implemented in both Québec and South Australia for more than a decade, a substantial body of literature surrounding the respective adoption of HIA and HLA exists. Accordingly, these jurisdictions represent exemplary cases from which “lessons learned” may prospectively inform HIA-related efforts within similar geographical and political contexts (Druet et al., 2010; Williams & Galicki, 2017)

Policy Transfer entails examination of the circumstances surrounding successful policies, programs, administrative arrangements and/or institutions, and how and to what extent these may be adopted elsewhere (Minkman et al., 2018). As such, it is a subset of the broader “innovation diffusion” literature focused on “the spread of new activities among individuals or organizations” (Wolman, 2009, p.2). Consideration of the seven “objects” of policy transfer may be usefully extended to the exploration of HIA adoption, including: 1) policy goals; 2) structure and content; 3) policy instruments or administrative techniques; 4) institutions; 5) ideology; 6) ideas, attitudes, and concepts; and/or 7) negative lessons (Dolowitz & Marsh, 1996). These authors also highlight different “degrees” of transfer, noting that both general ideas and specific instruments may be adopted. For example, whereas *copying* entails adopting a policy without changes, regions may also *emulate* existing programs by making context-specific adjustments. On the other hand, *hybridization and synthesis* entails combining program elements from two or more regions to “develop a policy best-suited to the emulator” (p.351). In this regard, whereas geographic proximity and socioeconomic/political congruence among neighbouring regions may facilitate exploration of existing programs, it would also benefit prospective adopters to extend their focus to other countries – particularly those deemed “established innovators” (Benson & Jordan, 2011; Wolman, 2009). Aggregating findings from numerous jurisdictions is noted to enhance the generalizability of policy transfer explanations (Minkman et al., 2018), with *ideological* and *resource* similarities, rather than geographic propinquity, as the “necessary preconditions” for adapting lessons from one region to another (Dolowitz & Marsh, 1996).

4.3 Problem and Research Objectives

In their seminal work, Dolowitz and Marsh (1996) identify three circumstances under which unsuccessful policy transfer takes place: 1) when it is *uninformed*, it occurs with insufficient knowledge about *why* an approach works in the original jurisdiction; 2) when it is *incomplete*, critical features do not accompany implementation within the new jurisdiction; and 3) when it is *inappropriate*, different contextual factors lead to

dissimilar outcomes. To avoid each, prospective adopters must possess a detailed understanding of *context* – that is, the political and cultural predispositions inherent to both innovator and recipient jurisdictions (March & McConnel, 2010). Accordingly, Wolman (2009) poses the general question, “*are there any aspects of a policy’s setting in the originating country that are critical to its success, but are not present, or present in a different form, in the recipient country?*” (p.22). In so doing, health promotion and protection strategies may be tailored to administrative arrangements and cultures, as is recommended for the sustained implementation of HIA (Bernier, 2006).

As mentioned, Québec remains the only Canadian region in which HIA has been implemented at the provincial level (Lysyk, 2019). As a significant proportion of health and social policy falls within provincial jurisdiction, the general lack of HIA uptake leaves room for governments to introduce unintended negative health impacts through public policies. **The present study therefore sought to explore the conditions sufficient for HIA use at the sub-national (e.g., provincial, state) level, with specific focus given to the political factors conducive to its adoption and sustained implementation.** Québec and South Australia were selected as exemplary regions wherein health impact tools have been used for at least a decade. ‘Political factors’ were broadly defined as *those entered into the larger system of government which interact to influence policy-related processes and outcomes in some way (e.g., facilitate, cause).*

Inspired by the ‘hybridization and synthesis’ approach to policy transfer, the aim of this study was to identify which political factors, if any, have contributed to the use of health impact tools in both regions – that is, those shared by Québec and South Australia. In so doing, the synthesized findings may serve as a useful blueprint for HIA proponents (i.e., “emulators”) operating within similar geographical and political contexts. Two research questions were addressed:

1. Which jurisdiction-specific political factors have contributed to the adoption and sustained implementation of impact assessment tools *within* the sub-national regions of Québec and South Australia?

2. Which political factors have consistently contributed to the adoption and sustained implementation of impact assessment tools *across* the sub-national regions of Québec and South Australia?

4.4 Literature Review

The following presents an overview of the political factors that may facilitate or impede HIA/HLA use by local (e.g., municipal), sub-national (e.g., provincial, state) and national governments. Although distinct factors (e.g., jurisdiction, institutional power) may affect government operations differently at each level, there is notable potential for vertical policy diffusion (e.g., Guglielmin et al., 2018; Linzalone et al., 2018). The present review of academic literature was guided by the nine political factors previously identified by Oneka et al. (2017): 1) political agenda; 2) political elites; 3) policy elites; 4) institutional power; 5) ideology; 6) jurisdiction; 7) resource allocation; 8) political culture; and 9) political support.

Political Agenda. A broad conceptualization of health and its antecedents appears to be a critical precursor to securing health impact tools on the *political agenda* – that is, “the subset of issues and policies upon which a government acts on at a given point in time” (Oneka et al., 2017, p.836). In British Columbia (Banken, 2001), Wales (Breeze & Hall, 2002), and New Zealand (Signal et al., 2006), for example, governments explicitly recognized the significant role of social, economic, and cultural health determinants prior to formal HIA adoption efforts. Moreover, by integrating health care and social services into one government department, Québec established a longstanding socially-oriented health agenda by the mid-1980s (Bernier, 2006; Boldo, 2011). Conversely, “traditional” views of health among policy actors or specific government sectors may impede the uptake of health impact tools (Breeze & Hall, 2002; Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006). For example, Berensson and Tillgren (2017) attribute decreased HIA use across Swedish regions to a prevailing healthcare focus at the national policy level whereas, in the Netherlands, the Ministry of Health’s primary responsibility for healthcare (e.g., financing, wait times) resulted in comparatively less investment in HIA awareness raising strategies (Put et al., 2001). In such instances, proponents may

seek to connect health impact tools to existing political agendas (Berensson & Tillgren, 2017; Bernier, 2006; Put et al., 2001; Signal et al., 2006). For example, HIA was notably aligned with sustainable development agendas in both Ticino, Switzerland (Mattig et al., 2015) and Wales (Breeze & Hall, 2001), whereas HLA was introduced as a means of attaining key government priorities within South Australia's Strategic Plan (Delany et al., 2015). In British Columbia, however, dramatic shifts in the province's health policy objectives saw HIA removed from the political agenda altogether (Banken, 2001). High-level support among political elites is therefore critical to securing HIA on the political agenda (Berensson & Tillgren, 2017; Breeze & Hall, 2002; Delany et al., 2014; Harris & Spickett, 2011; Signal et al., 2006). On the other hand, the agendas of non-health sectors (Breeze & Hall, 2002; Put et al., 2001) and, in particular, those of more economically-oriented policy areas (Gagnon et al., 2008; Manheimer, 2007; Mattig et al., 2015) may prevent broader investment in HIA, as health outcomes are often deemed irrelevant to key objectives.

Political Elites. Another critical precursor to the implementation of health impact tools includes high-level support or buy-in among *political elites* – that is, those with authoritative and privileged positions within government (Oneka et al., 2017). In this regard, leadership is considered by some to be the most important determinant of HIA use (e.g., Gagnon et al., 2008). In British Columbia, early support from the province's Deputy Minister of Health and Premier's Office secured HIA on the political agenda and facilitated its integration into policy analysis at cabinet level (Banken, 2001). Similarly, South Australia's HLA tool was formally endorsed by the Premier's Office, which also secured its use via a central government mandate (Delany et al., 2014; Harris & Spickett, 2011). Elsewhere, government health sectors in the Netherlands (Put et al., 2001), New Zealand (Signal et al., 2006), and Slovakia (O'Mullane, 2014) took clear steps to support early HIA implementation. In the latter case, for example, Slovakia's Ministry of Health Care worked alongside the WHO to organize an HIA capacity-building workshop including learning initiatives related to the SDoH, equity, and policy appraisal (O'Mullane, 2014). Political elites in other regions have also employed committee structures to support health impact initiatives (Gagnon, 2008; Mattig, 2015; Signal et al.,

2006). For example, in 1995 Sweden established a “Public Health Program” comprised in part of municipal politicians tasked with securing health objectives, including HIA, on the local political agenda (Berensson & Tillgren, 2017). In contrast, lack of commitment to HIA/HLA among political elites is a notable barrier to their uptake (Banken, 2001; Gagnon et al., 2008; Harris & Spickett, 2011; O’Mullane, 2014).

Policy Elites. In some regions, HIA and HLA use has also been championed by *policy elites*, defined by Oneka and colleagues as “those who work within or have significant knowledge of a specific area of policy, and thus have significant influence over the policymaking process” (2017, p.836). In South Australia, the central role of Professor Ilona Kickbusch in fostering the adoption and sustained implementation of HLA is perhaps the best documented and thus most widely-cited example of the potential impact of policy elites (Delany et al., 2014; Harris & Spickett, 2011). Similar strategies have been employed elsewhere. For example, the methodological basis for HIA in the Netherlands was heavily informed by the research of former politician and healthcare policy professor, Dr. Kim Putters (Put et al., 2001). In New Zealand, a HIA Guide was informed via consultations between the national Public Health Advisory Committee, an external advisory group, and international peer reviewers (Signal et al., 2006). However, policy entrepreneurs may also impede HIA/HLA uptake. Gagnon et al. (2008) note that in Québec, for example, social and economic sectors have espoused conflicting solutions to the same issues, with the latter typically relying on “the logic of productivity and profitability” (p.15). Similarly, Switzerland’s business sector, with notable political influence, unanimously opposed HIA due to possible regulatory burdens stemming from its use (Mattig et al., 2015).

Institutional Power. HIA/HLA use may be incentivized, facilitated, or enforced via different *institutional power* mechanisms designed to “influence the behaviour of others to impact decisions and achieve desired outcomes” (Oneka et al., 2017, p.836). For example, Québec’s HIA tool functions to support non-health government ministries in identifying the potential health impacts of their policies, as is required under section 54 of the province’s Public Health Act (Boldo et al., 2011). Moreover, the “moral authority”

granted to the Minister of Health and Social Services through section 54 effectively mandates healthy public policy (Bernier, 2006; Gagnon et al., 2008). Similarly, HIA was integrated into the Health Act in Geneva, Switzerland (Mattig et al., 2015) and the Public Health and Wellbeing Act (2008) in Victoria, Australia (Harris & Spickett, 2011). In this regard, Signal et al. (2006) note a widespread consensus that legal frameworks offer one of the most robust means of institutionalizing HIA, particularly at the national level. Conversely, Gagnon et al. (2008) conclude that effective legal “constraints” must be accompanied by political and administrative leadership, whereas Harris and Spickett (2011) note that capacity building may be more valuable than HIA-related legislation. One strategy to complement the use of mandates may therefore include securing high-level champions or support (Manheimer et al., 2007). For example, to ensure the use of HIA, South Australia’s central government explicitly championed its adoption and subsequently adapted existing accountability mechanisms linked directly to the Department of Premier and Cabinet (Delany et al., 2014). Elsewhere, the integration of HIA into British Columbia’s “Cabinet Document System” embedded its use alongside the other required components of cabinet submissions (Banken, 2001). Similarly, research from Québec (Bernier, 2006), Wales (Breeze & Hall, 2002) and New Zealand (Signal et al., 2006) highlight the value of incorporating HIA into existing policy development processes and organizational cultures. Alternatively, lack of binding requirements for HIA is considered by some to impede its uptake (Diallo & Freeman, 2020; Mattig et al., 2015). In British Columbia, for example, the momentum surrounding HIA was significantly diminished once its use was rendered optional rather than mandatory (Banken, 2001).

Ideology. Oneka and colleagues define *ideology* as normative and causal arguments regarding the creation and maintenance of health and well-being: “influential actors often rely on ideological constructs to generate blueprints for policy action” (2017, p.837). In this regard, both a recognition of the broad social and economic determinants of health (Banken, 2001; Bernier, 2006; Put et al., 2001) and buy-in among political elites (Gagnon et al., 2008; Manheimer et al., 2007; Signal et al., 2006) have fostered HIA uptake internationally. Prior to its adoption in Sweden, for example, parliament established an

overarching public health aim to entail “the provision of societal conditions for good health on equal terms for the entire population” (Berensson & Tillgren, 2017, p.44). Elsewhere, health impact approaches have aligned with both government and societal values. For example, in New South Wales, Australia, HIA’s underlying principles of democracy, equity, and sustainability were consistent with the state’s aim to address equity “internally and collaboratively” across government (Delany et al., 2014, p.3). In some instances, ideological discrepancies may exist within government, as was the case between economic, health, and environmental sectors in Québec (Gagnon et al., 2008). Moreover, Delany and colleagues note that because South Australia’s HIA tool is highly contingent on the priorities of government, the scope of its use may be limited. In British Columbia, dramatic shifts in the province’s health policy priorities following the 1996 re-election of the New Democratic Party removed HIA from the political agenda, thereby suggesting that ideological orientation alone may not be the most robust predictor of HIA-related outcomes (Banken, 2001).

Resource Allocation. The adoption and sustained implementation of health impact tools typically necessitate significant and ongoing human, informational, financial and/or infrastructural support (Oneka et al., 2017). International ‘capacity building’ efforts have relied on informational resources such as HIA workshops, guides and toolkits designed to enhance awareness of the SDoH and healthy public policies among HIA proponents (Banken, 2001; Boldo et al., 2011; Diallo & Freeman, 2020; Breeze & Hall, 2002; Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006). Moreover, HIA training (Banken, 2001; Berensson & Tillgren, 2017; Harris & Spickett, 2011; O’Mullane, 2014; Signal et al., 2006) and pilot testing (Breeze & Hall, 2002; Harris & Spickett, 2011; Manheimer et al., 2007; Mattig et al., 2015; Put et al., 2001) require notable financial allocation, human expertise, and time and engagement to generate understanding and confidence surrounding HIA. In Québec, ongoing HIA use has been supported by both a committee comprised of various departmental representatives (Diallo & Freeman, 2020), and expertise, training, and tool development offered by the National Collaborating Centre for Healthy Public Policy (NCCHPP) (Gagnon et al., 2008). Similar technical and resource support may be offered by designated units within government (Banken, 2001;

Delany et al., 2014), academic institutions (Breeze & Hall, 2002; Harris & Spickett, 2011) and adjunct (i.e., government-independent) entities (Mattig et al., 2015; Put et al., 2001).

Political Culture. Health impact tools are typically adopted within government contexts characterized by distinct and embedded *political cultures* – that is, shared attitudes, norms, beliefs, or values (Oneka et al., 2017). The integration of public health functions within Québec’s existing health and social service system represents a noteworthy effort to cultivate a political culture conducive to healthy public policy. As Bernier (2006) explains, doing so “[fostered] the inclusion of a ‘social’ or progressive agenda within the structures of Québec’s most important ministry” (p.32), thereby strengthening action on public health and the SDoH. Integrating HIA into existing structures, rules, and procedures (i.e., “institutionalization”) may also enhance buy-in across sectors and facilitate its use (Breeze & Hall, 2002; Signal et al., 2006). Given the often deeply entrenched nature of political and organizational cultures, however, existing mentalities or values may create significant barriers to HIA adoption (Breeze & Hall, 2002; Manheimer et al., 2017; O’Mullane, 2014; Signal et al., 2006). Accordingly, HIA implementation would ideally be accompanied by ongoing efforts to foster a culture of collaboration across the contexts of its use (Boldo et al., 2011; Delany et al., 2014). This may include efforts to avoid ‘health imperialism’ – that is, the imposition of a ‘health agenda’ within non-health sectors. In South Australia, for example, HIA entails a *win-win* approach through which the core business of sectors must be advanced while simultaneously promoting health (Harris & Spickett, 2011).

Jurisdiction. Central to systematically assessing non-health sector policies for their potential health impacts is the issue of *jurisdiction* – that is, “how authority over and political responsibility for policy issues is distributed across formally constituted bodies in government” (Oneka et al., 2017, p.837). While a broad conception of ‘health’ and its antecedents may be a critical precursor to HIA adoption, such views are not always shared across sectors (Breeze & Hall, 2002; Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006). Consequently, HIA uptake may be impeded by departmental ‘silos’

(Breeze & Hall, 2002) and the longstanding rules, norms, or values (i.e., cultures) therein (Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006). Moreover, while actors within economically-oriented sectors may consider health outcomes to fall beyond their respective jurisdictions (Breeze & Hall, 2002; Gagnon et al., 2008; Signal et al., 2006), this perception is not necessarily unique to non-health sectors. For example, considerations of broader health determinants may be diminished within health sectors whose policy purviews are limited to the traditional healthcare realm (Berensson & Tillgren, 2017; Put et al., 2001). Thus, efforts to foster a culture of collaboration may further seek to address jurisdiction-related issues (Boldo et al., 2011; Breeze & Hall, 2002). In South Australia, for example, a Health in All Policies (HiAP) Unit facilitated the conduct of HLAs by providing technical and resource expertise, and employing a ‘win-win’ approach through which non-health objectives remained central to collaborative efforts (Delany et al., 2014; Harris & Spickett, 2011). While efforts to avoid perceptions of *health imperialism* are key to preserving existing jurisdictions and securing buy-in among non-health sectors (Breeze & Hall, 2002; Harris & Spickett, 2011), efforts to enhance system capacity for HIA, including the ongoing provision of training and information sessions, may generate the necessary confidence and understanding in health and non-health sectors alike (Berensson & Tillgren, 2017; Diallo & Freeman, 2020; Harris & Spickett, 2011; O’Mullane, 2014; Manheimer et al., 2007; Signal et al., 2006).

4.5 Methods: Framework Analysis

Framework analysis is a means of systematically collecting, analyzing, and reducing qualitative data to provide a descriptive overview of context-specific phenomena. Central to this method is an analytic matrix through which data are captured, organized, and interpreted (Smith & Firth, 2011). Each matrix presents *cases* as rows, and recurrent *themes* as columns. The latter may be informed at the outset of the analysis according to relevant literature, and the research questions and study data (Ritchie & Spencer, 2002). The framework is then systematically applied to the entire data set so as to support or refine existing themes, or identify those that emerge through inductive analysis. Distilled

data summaries are entered into corresponding matrix cells to allow the researcher to identify meaningful patterns and associations both within and between cases (Gale et al., 2013). The five stages of framework analysis include: 1) familiarization; 2) identifying a thematic framework; 3) indexing; 4) charting; and 5) mapping and interpretation.

4.5.1 Framework Analysis Adapted

The present analysis entailed three noteworthy modifications to the Framework method. First, whereas *cases* are typically defined as individual participants (Gale et al., 2013), South Australia and Québec instead served as jurisdictional units of analysis. Accordingly, the second adaptation entailed substituting interview transcripts with various types of literature. As such, the “literature review” was conceptualized as “the whole process of bringing together evidence which can be drawn from research and other sources relevant to a particular decision in a policy context” (Mays et al., 2007, p.7). Like past adaptations by Oliver et al. (2008) and Parker et al. (2011), the literature collected, including reports, commentaries, editorials, and government publications, were treated as ‘transcripts’ for secondary analysis. Finally, nine political factors identified by Oneka et al. (2017) were used as pre-established themes to guide the analysis. Each factor, including *political agenda*, *political elites*, *policy elites*, *institutional power*, *ideology*, *jurisdiction*, *resource allocation*, *political culture*, and *political support* (defined in Appendix H) has been demonstrated to influence HiAP implementation. The authors note, however, “the definitions presented here are normative and thus contestable” (p.835). Thus, the themes were confirmed or refined through analysis, with the final framework serving as a useful starting point for actors seeking to gauge the feasibility of similar strategic directions: “framework analysis displays the data so that the readers navigate the charts to find evidence related to their circumstances, or the options available to them” (Oliver et al., 2008, p.80).

4.5.2 Stages of the Framework Analysis

Stage 1: Case Article Search and Retrieval

South Australia: “*Health Lens Analysis*”, “*Health in All Policies*”, and ‘*South Australia*’ were combined as exact phrases using Boolean operators, with search terms limited to titles, abstracts and keywords. This resulted in 142 returns from Scopus, 12 from ProQuest, and 99 from PubMed. Inclusion criteria were applied for an initial screening of titles and abstracts, with articles retained if they: 1) focused on HLA or HiAP; 2) were published between 2007-2019; and 3) were published in English.

No limits were placed on the type of literature collected. Once duplicates were removed, 23 case articles were collected from Scopus, and four from ProQuest. A basic search was additionally conducted via Google Scholar, with the above inclusion criteria applied to the first seven pages of a total of 105 results. Two additional case articles were collected. Finally, a full-text review determined the 29 remaining case articles to be relevant if they: 1) discussed HLA implementation in South Australia; or 2) discussed related political factors. A total of 17 case articles specific to South Australia were retained for the framework analysis.

Québec. “*Health Impact Assessment*”, “*Public Health Act*” and *Quebec* were combined as exact phrases using Boolean operators, with search terms limited to titles, abstracts, and keywords. This saw 26 returns from Scopus, 19 from ProQuest, and seven from PubMed. Inclusion criteria were applied for an initial screening of titles and abstracts, with articles retained if they: 1) focused on HIA at the provincial level, Québec’s Public Health Act (2002), or the Institut National de Santé Publique du Québec (INSPQ); 2) were published between 2003-2019; and 3) were published in English.

No limits were placed on the type of literature collected. Once duplicates were removed, five articles were retained from Scopus, and two from ProQuest. Basic searches were additionally conducted through Google Scholar, and the websites for the INSPQ and National Collaborating Centre for Healthy Public Policy (NCCCHPP). As Québec’s public

health department, the INSPQ provides expertise and references pertaining to health impact assessment as it is used both within and beyond the province. As one of six National Collaborating Centres for Public Health, the NCCHPP provides research and expertise in the areas of public health, healthy public policy, and knowledge translation and synthesis. “*Health Impact Assessment + Quebec*” was entered into the search bars of both websites and, after applying the above criteria, four articles were retained from INSPQ, and six from NCCHPP. Four additional articles were collected via Google Scholar after the first seven pages were screened. Finally, a full-text review determined the 21 remaining case articles to be relevant if they: 1) discussed the implementation of HIA at the provincial level; or 2) discussed related political factors. A total of 12 case articles specific to Québec were retained for the framework analysis.

Stage 2: Familiarization with the Case Articles

Familiarization establishes a high-level overview of the depth and breadth of study data to gain early insights into key ideas and recurrent themes (Braun & Clarke, 2006). Doing so ensures that the final framework is supported by the study data (Ritchie & Spencer, 2002), thereby enhancing its *credibility* (Tobin & Begley, 2004).

Two jurisdiction-specific samples were chosen for this stage, as reviewing select sources is ideal where the data set is expansive yet relatively homogenous (Ritchie & Spencer, 2002). Half of the articles from both sets were selected at random. To the extent possible, care was taken to include a range of issues and author perspectives (Brooks et al., 2015). To enhance the *rigour* of this process, a sample from both sets of case articles was reviewed by the dissertation supervisor.

Stage 3: Developing the Working Analytical Thematic Frameworks

The nine political factors identified by Oneka et al. (2017) were established as overarching themes within a preliminary framework (i.e., codebook) to guide a more thorough analysis of the case articles. Initial second- and third-order themes were derived from the authors’ descriptions of each factor, and further refined through familiarization.

This process resulted in a working framework specific to each jurisdiction. To enhance the *confirmability* of the analysis, the working frameworks were reviewed by the dissertation supervisor prior to their application to the entire data set (Smith & Firth, 2011).

Stage 4: Applying the Analytical Framework

The case articles were uploaded to NVivo 12 qualitative software and coded against the working frameworks developed at the previous stage. The *dependability* and *confirmability* of the analysis was enhanced through use of NVivo's audit trail and analytic memo options (Hackett & Strickland, 2018). Given the interconnected nature of the nine political factors, it was important to identify connections and associations between themes (Ritchie & Spencer, 2002) while at the same time ensuring that each remained conceptually distinct (Ward et al., 2013). Upon completion, the final codebooks were reviewed by the dissertation supervisor.

Stage 5: Charting (Data Summary and Display)

Charting entails distilling the data into succinct yet informative summaries within their corresponding matrix cells (Ward et al., 2013). Data *within* each cell should cohere meaningfully while demonstrating clear distinctions *between* themes (Braun & Clarke, 2006). Given the jurisdiction-specific focus of the analysis, the charts were laid out according to *case* (i.e., one chart per region) (see Appendix I). This allowed for comparison of the political factors across Québec and South Australia, thereby facilitating the subsequent *synthesis* stage.

Stage 6: Synthesis

The final stage of Framework Analysis entails identifying patterns and connections between cases by comparing their corresponding themes and data. The present synthesis sought to achieve one of the three possible outcomes identified by Ritchie and Spencer (2002) – that is, to *develop strategies* for the future implementation of health impact tools within jurisdictions comparable to Québec and South Australia. To do so, the charts

developed during the previous stage were compared and contrasted to identify which, if any, political factors were shared by the two regions of interest. This required close consideration of the nuances of each, including how and to what extent they are linked to or contingent upon others (Gale et al., 2013). The consistent factors were then synthesized into a final framework output.

4.6 Findings

4.6.1 South Australia

The following details the political factors surrounding the adoption and sustained implementation of HLA in the sub-national state of South Australia. The resultant jurisdiction-specific framework output is provided in Appendix J.

4.6.1.1 Agenda Setting

Ideology – “the set of ideas, including values and beliefs, according to which people generate normative and causal arguments” (Oneka et al., 2017, p.837)

In 2003, the South Australian Labour Government came into power under the leadership of Premier Mike Rann. Reflecting on his nine years in office, Premier Rann described his governance stance as largely centrist, with issue such as social inclusion approached from the left, and crime and economic policy from the right (Manwaring, 2011). Accordingly, he is noted to have “taken policies wherever he [found] them, regardless of context” (p.11) rather than aligning with the traditions of social democracy and labourism. This notwithstanding, South Australia’s government was dedicated to enhancing the economy through a pro-business agenda.

In 2003, Premier Rann appointed the State’s *Economic Development Board* (EDB) to advise on “maximizing the value of emerging economic opportunities for the State” (Tagliaferri, 2011, p.22). Following an extensive evaluation, the EDB recommended high-level strategic framework to guide government action on social, environmental, and economic goals. South Australia’s Strategic Plan (SASP) was subsequently implemented in 2004 as a ‘*whole-of-government*’ strategy to “enhance the state’s prosperity,

sustainability and quality of life for its citizens” (Government of South Australia, 2013, p.3). To do so, key targets fell under one of six objectives: *growing prosperity; improving wellbeing; attaining sustainability; fostering creativity and innovation; building communities; and expanding opportunity* (Kickbusch & Buckett, 2010). SASP emphasized the interdependence of each target, thereby requiring a ‘joined-up’ government approach to bridge traditionally siloed policy domains (Delany et al., 2014).

Political Culture – “the histories of political systems and individual members of those systems... members share attitudes, norms, beliefs or values” (Oneka et al., 2017, p.837)

At the outset of efforts to bring HiAP to the political agenda, South Australia was in the midst of an enduring economic struggle due in part to increasing healthcare costs (Buckett et al., 2011). Deemed by some to have escalated to a “budgetary crisis” (e.g., Kickbusch et al., 2014), the state relied on an economic projection to advocate for proactive cost containment strategies: “health currently consumes close to 30% of the total state budget...without change, it will consume the entire budget in less than 25 years” (as cited in de Leeuw, 2017, p.336). Some highlighted the likelihood of a ‘*double whammy*’ stemming from this trajectory whereby workforce productivity and economic growth would be significantly diminished by the ageing population and younger generations predisposed to chronic disease. Government operations were thus underpinned by a shared sense of *urgency* as “bureaucrats across government [were] dealing with budget constraints emanating from health’s burgeoning budget” (Kickbusch et al., 2014, p.187).

Despite pressing healthcare costs, South Australia had a notable history of intersectoral efforts to enhance public health. As such, the state had an established legacy of social innovation, justice, and policy (Government of South Australia, 2011; Lawless et al., 2018). This further contributed to a political culture that was especially receptive to novel and collaborative approaches to health promotion (Baum et al., 2015). Lawless et al. (2018) note that, with time, those immersed within this culture ‘on the ground’ were able

to ascend to more senior positions “with the knowledge, skills, and capacity to advocate and implement ideas associated with [HiAP]” (p.514).

Political Elites – “*people holding ‘authoritative positions’ who, by virtue of their privileged positions within government, tend to have regular and greater influence than policy elites*” – (Oneka et al., 2017, p.836)

In pursuing his joined-up agenda, Premier Rann sought advice in the form of unique ideas, inventive thinking, and evidence of effective strategies (Baum et al., 2015). Accordingly, he was willing to take risks, challenge existing bureaucratic structures and policy norms, and lead by example for other jurisdictions (Baum et al., 2015). To do so, he established South Australia’s 2003 *Thinker in Residence* program. As both a key strategic and informational resource until its 2009 dissolution, the program consisted of international expert advisors (i.e., *policy elites*) commissioned to present innovative solutions to pressing issues. While some “Thinkers” were selected specifically by Premier Rann, most were nominated by the public sector, with final decisions made through the Department of Premier and Cabinet (DPC) (Manwaring, 2018).

In 2007, the Thinkers provided innovative and strategic directions regarding the implementation of SASP as the overarching operational framework of the state government (Baum et al., 2015). Based on their expertise, each was assigned to a SASP target to “generate new thinking, inspire momentum, [and] provoke change” (Kickbusch et al., 2014, p.187). The “tangible benefits” of proactive action on the SASP targets were of primary interest (Baum et al., 2015, p.2).

The Thinkers delivered recommendations to key political elites including Premier Rann and his Cabinet members (Kickbusch et al., 2008). As this direct access constituted an opportunity rarely granted to academics or lower-level bureaucrats, Baum et al. (2015) borrow from Kingdon (2011) in describing it as a *claim to hearing* – that is, “the right to be listened to by those with power to effect change” (p.7). Accordingly, the Thinkers had a unique status as both *policy elites* (i.e., those with policy expertise) and *external political elites* (i.e., independent from government but with high-level internal access).

This positioning was critical to the success of the Thinkers in Residence program (Baum et al., 2015).

Policy Elites – “actors who have significant knowledge of a specific area of policy, and thus have significant influence over the policymaking process.” (Oneka et al., 2017, p.836).

Professor Ilona Kickbusch was appointed to South Australia’s Thinker in Residence program in 2007. Given her expertise in health policy, Kickbusch was tasked with developing innovative approaches to health, wellbeing, and health governance under an overarching ‘*Healthy Societies*’ initiative (Buckett et al., 2011). She was also appointed based on her senior positions within the WHO and the European Union (Baum et al., 2015). With her international reputation having strengthened her authority as both a policy and political elite (Manwaring, 2018), Kickbusch was a ‘catalyst’ in bringing HiAP to the political agenda (Kickbusch & Buckett, 2010).

In light of escalating healthcare costs, one objective of Kickbusch’s tenure was to reorient the state toward upstream health promotion (Manwaring, 2018). In this regard, she served as an informational resource by highlighting the “array of health challenges faced in the 21st century, and [providing] a vision for addressing these through ... [integrating] health concerns into the policy process” (Baum et al., 2015, p.4). Specifically, she introduced the concept of “new public health” to educate political and public service policymakers on the SDoH, and the role of all government sectors in their creation and modification (Kickbusch & Buckett, 2010). This demonstrated the logic of investing in disease prevention and health promotion, and adopting an intersectoral approach to public policy development (Baum et al., 2015; Lawless, 2018).

As a key component of her report on health in the 21st century, Kickbusch recommended that the government implement a HiAP strategy (Kickbusch & Buckett, 2010). A crucial consideration therefore entailed “how to place health criteria on the agendas of policymakers who have not previously considered health as part of their agendas, or who may not see the value of such an approach” (p.78). Accordingly, Kickbusch identified

SASP as a “blueprint for action” given its alignment with the SDoH. Specifically, she argued that applying a “health lens” to SASP’s key targets would positively impact the health and wellbeing of the population, and contribute to a long-term reduction in healthcare costs (Government of South Australia, 2013). This *win-win* approach was designed to encourage proactive collaboration between government sectors, as the achievement of SASP targets may be enhanced and, as a result, population health outcomes improved (Government of South Australia, 2013; Kickbusch et al., 2014).

The reframing of health as an “economic driver” was critical to securing HiAP on the political agenda (Baum et al., 2015, p.6). Specifically, this strategy capitalized on both the economic imperatives of the South Australian government and its existing commitment to SASP, and offered an innovative means of advancing the Premier’s joined-up agenda. Moreover, it established an entry point for health actors to become involved in ‘non-health’ policy areas, thereby cementing a “whole-of-government” component notably absent from prior joined-up efforts (Williams & Galicki, 2017, 2017). As a key strategic and informational resource, the Thinker in Residence program was thus a critical factor in unlocking the health potential of the SASP targets and, as a policy elite, Ilona Kickbusch was instrumental in reorienting government investment and priorities toward disease prevention and health promotion strategies.

Jurisdiction – “*how authority over and political responsibility for policy issues is distributed across formally constituted bodies of government.*” (Oneka et al., 2017, p.837)

Connecting HiAP to SASP was underscored by a number of jurisdiction-related considerations to enhance non-health sector buy-in. As a framework for strategic priorities and policy imperatives, the South Australian government was highly committed to achieving SASP’s key targets (Government of South Australia, 2013). This commitment was largely maintained through two factors. First, each department was mandated to monitor implementation strategies, performance indicators, and key milestones within given timeframes (Kickbusch & Buckett, 2010). Second, until 2013, departmental Chief Executives were required to report progress on the targets directly to

the Premier (Buckett et al., 2011). HiAP could thus be connected to the ‘core business’ objectives of each department for which there were both high-level mandates and pre-established reporting and accountability mechanisms (Lawless et al., 2018). This strategy provided a whole-of-government mandate for action through which health sector entry into other policy jurisdictions could be legitimized (Government of South Australia, 2011; Lawless et al., 2018). Moreover, by using existing vertical governance structures, the health sector could contribute to traditionally siloed policy sectors in a way that would adhere to, rather than challenge, department-specific norms and processes (Kickbusch et al., 2014; Williams & Galicki, 2017).

As an additional strategy to enhance non-health sector buy-in, Kickbusch recommended that HiAP oversight fall within the jurisdiction of the Department of Premier and Cabinet (DPC) rather than the Department of Health (DH). This advice “implicitly [recognized] the difficulty that a line agency, such as health, has in trying to instigate a whole-of-government approach to its own policy agenda” (Kickbusch & Buckett, 2010, p.90). Together with adhering to non-health sector mandates and existing governance structures, these details were critical to avoiding *health imperialism* – that is, perceptions of health sector dominance or interference (Oneka et al., 2017).

4.6.1.2 Pre-Implementation Strategies

4.6.1.2.1 Policy Learning

To progress the HiAP agenda, its relevance and feasibility was first demonstrated through a *policy learning* strategy designed to enhance buy-in across government. This strategy was premised on the recognition that health promotion and protection are often considered to fall beyond the policy jurisdictions of non-health sectors (Buckett et al., 2011). South Australia’s pre-implementation policy learning initiative was thus comprised of three interconnected components (Table 1). As key *informational resources*, these contributed to the *demonstrated utility* of HiAP– that is, the confidence and capacity to undertake HiAP and related processes through evidence of their causal

feasibility and value. Moreover, establishing the “how-to” of HiAP effectively moved the proposed initiative from theory to practice (Kickbusch et al., 2013).

Table 3: Three Components of South Australia’s Policy Learning Strategy (2007)

Policy Learning	Example of Component Aims	Example of Buy-in Strategies
Component 1: Rapid analysis of a sample of South Australia Strategic Plan (SASP) targets	Identify key interactions and synergies between SASP targets and health outcomes (i.e., apply ‘health lens’ prototype).	Conducted by central government rather than DH, demonstrating a ‘real life’ example of a HiAP approach.
Component 2: Case studies detailing results from seven of 14 desktop analyses	Discussion papers presenting key interactions between SASP targets and health outcomes	Provide opportunity for government actors to develop win-win strategies for respective SASP targets.
Component 3: HiAP conference hosted by DPC and the DH	Work with chief and senior executives across government to map out HiAP implementation.	Demonstrate connection between population health, the economy, and SASP targets.

Following the conference, HiAP received widespread support across government sectors, and was formally endorsed by the DPC (Government of South Australia, 2011). South Australia’s pre-implementation policy learning strategy was thus instrumental in progressing this agenda toward implementation (Kickbusch & Buckett, 2010).

A number of key documents stemmed from the three policy learning components, including *South Australia’s Strategic Plan through a Health Lens* (Government of South Australia, 2007ba), and *Health in All Policies: the 10 Principles* (Government of South Australia, 2007b) – the latter of which “reflects health as a shared goal of all government” (p.1). These resources provided a foundation for the second pre-implementation strategy, as follows.

4.6.1.3 Establishing Intersectoral Mechanisms

South Australia's second pre-implementation strategy sought to develop an initial HiAP model, with primacy given to *win-win* outcomes for both health and non-health sectors (Lawless, 2018). Two key mechanisms to facilitate intersectoral collaboration were initially established: 1) a health lens analysis (HLA) tool; and 2) central governance and accountability structures. The co-benefits approach through which both health and non-health sectors *must* achieve favourable policy outcomes has since remained integral to HiAP (Williams & Galicki, 2017). Both mechanisms align with what Oneka et al. (2017) deem *institutional power* – that is, “the ability to influence the behaviour of others to impact decisions and achieve desired outcomes” (p.836).

HLA. An HLA tool was trialed as a mechanism to facilitate collaborative policy development, and has remained a key component of South Australia's HiAP approach (Kickbusch et al., 2014). As an operational process, HLA aimed to unlock the health potential of SASP targets by identifying interactions and synergies between policies and population health outcomes (Kickbusch & Buckett, 2010). To do so, the core business of non-health agencies was positioned as starting points, with equal consideration given to health concerns as “substantive issues which can contribute to the achievement of specific sectoral targets” (Delany et al., 2014, p.5). In each case, collaborating sectors sought *win-win* outcomes, where SASP targets were met through robust public policies, and health gains simultaneously maximized and or/negative impacts mitigated (Buckett et al., 2011). The government described HLA as “essentially a project which aims to develop systemic change through evidence-based recommendations (2011, p.28).

Governance Structures. The state drew on a number of strategies employed nationally and internationally to strengthen intersectoral relationships and foster a sense of shared responsibility for policy initiatives (Government of South Australia, 2011). Four central governance components were established to support the early implementation of HiAP (see Table 2).

Table 4: Four Components of South Australia’s Governance Structures Strategy (2008)

Governance Mechanism	Intersectoral Approach	Anticipated Intersectoral Outcomes
Central Government Leadership	DPC acts as central authority and leader of HiAP initiative.	Clear commitment from, and benefits to, all sectors will foster a sense of joint responsibility and improve HiAP engagement across government.
Cross Government Mandate (SASP)	Connect HiAP implementation to existing SASP reporting and accountability structures (i.e., central government).	Government’s existing commitment to attaining SASP targets will see government-wide HiAP engagement as sectors seek win-win outcomes.
Health in All Policies Unit	Under direction of central government, DH provides technical expertise to guide application of a ‘health lens’ to SASP targets.	DH as facilitators rather than owners of HiAP initiative will improve engagement across government as win-wins sought
Priority Setting Process	Central government and HiAP Unit undertake annual review of existing departmental commitments and emerging priorities.	Determining which SASP targets are best supported by HiAP will foster joint responsibility and improve engagement across government.

The political factors contributing to the operationalization of both the central governance structures and HLA are detailed in the following section.

4.6.1.4 Implementation

Jurisdiction – “*how authority over and political responsibility for policy issues is distributed across formally constituted bodies in government*” (Oneka et al., 2017, p.837).

HiAP was implemented in 2008 to enhance horizontal collaboration between state government departments (Baum et al., 2019). Central to this undertaking were efforts to preserve both the authority and responsibilities of non-health sectors, while at the same time providing impetus to engage across traditional jurisdictional boundaries. Avoiding perceptions of *health imperialism* (i.e., health sector interference or dominance) was therefore critical. To do so, HiAP was jointly overseen by the DPC and DH. This approach received widespread support, thereby facilitating implementation in two ways. First, leadership from the DPC provided a high-level mandate from the state’s central government authority. Second, it ensured clear commitment and support across all of government, rather than the DH alone (Government of South Australia, 2011). The joint approach therefore enhanced the legitimacy of HiAP and permitted health sector entry into other departments as *facilitators* rather than *owners* of the initiative (Delany et al., 2014).

Institutional power is a political factor through which “actors may seek to change governance structures and use expertise to create and legitimize shared meanings and values that produce specific results” (Oneka et al., 2017, p.836). In addition to the high-level mandate, institutional power was further established through a 2009 Memorandum of Understanding (MOU) between central government and the DH (Government of South Australia, 2013). The agreement operationalized the second pre-implementation strategy, with central government responsible for the coordination of HiAP through its reporting and accountability structures, and the DH for assisting with HLA (Kickbusch & Buckett,

2010). Institutional power was thus central to establishing the jurisdiction surrounding HiAP, as follows.

Executive Committee of Cabinet (ExComm). Oversight for HiAP was assigned to ExComm – a branch of the DPC already overseeing the implementation of SASP (Government of South Australia, 2013). Chaired by the Premier, the Minister of Health was notably absent from this newfound HiAP governance structure (Buckett et al., 2011).

ExComm’s Chief Executive Group (ExComm CEG). As the subcommittee actively implementing SASP, the operationalization of HiAP was allocated to the ExComm CEG. The departmental Chief Executives comprising ExComm CEG reported to ExComm on the application of HLA to their respective SASP targets (Buckett et al., 2011).

The MOU guiding the state’s joint governance approach distinguished the roles of the DPC and DH in supporting ExComm CEG. Specifically, the above reporting and accountability structures directly linked department operations to the Premier, whose oversight provided impetus to adhere to the high-level mandate. To assist this process, the DH established a catalyst HiAP Unit.

HiAP Unit. In 2008, the Department of Health provided financial, human and information resources to establish a HiAP Unit tasked with facilitating HLA projects (Government of South Australia, 2011). Oneka and colleagues identify *resource allocation* as a political factor through which various means are distributed to enhance the feasibility of HiAP. As a key infrastructural resource, the Unit helped to further establish the *jurisdiction* surrounding HiAP.

At the height of its operation, the HiAP Unit employed six public servants from the DH who, under direction from central government, worked to implement HiAP on a full-time basis (Williams & Galicki, 2017). As the policy priorities and core objective of non-health sectors, SASP targets served as the starting point for each HLA. Personnel from both sides of the partnership then engaged in a symbiotic learning process; staff from the HiAP Unit familiarized themselves with the policy area under investigation, while those

from host agencies aimed to connect their objectives to potential health outcomes (Lawless et al., 2018). As these efforts represented a “genuine attempt to understand and work within the policy parameters of the other agency” (Kickbusch & Buckett, 2010, p.111), such reciprocity was a key driver of both the shared ownership and win-win approach underscoring HLA. Moreover, to further a sense of ownership, each jointly developed policy solution was approved through existing departmental structures, thereby “maintaining the authority and policy responsibility of individual Chief Executives and executive leadership teams” (Williams & Galicki, 2017, p.28).

4.6.1.5 Sustained Implementation

South Australia’s HiAP initiative has been refined and adapted in response to political and bureaucratic changes. Lin and Kickbusch (2017) describe this approach as iterative, with ‘*lessons learned*’ informing subsequent phases of the HiAP model. Thus, consistent with Premier Rann’s willingness to take risks to progress his joined-up agenda, the sustained implementation of HiAP has largely benefitted from ‘*learning by doing*’ (Delany et al., 2014).

The following details *political elites, jurisdiction, institutional power, and demonstrated utility* as key drivers of the ‘learning by doing’ approach. Together these political factors have fostered a *political culture* conducive to the sustained implementation of HiAP.

Political Elites – “*Whether governments are successful in implementing HiAP may depend on . . . the ideologies and political agendas of political elites*” (Oneka et al., 2017, p.836).

HiAP was developed and implemented under Premier Mike Rann, who held office for two terms between 2003-2011. The Labour Party was subsequently re-elected under new leadership, and remained in power until 2018 (Government of South Australia, 2019). The first 10 years HiAP was thus overseen by the longest-serving Labour government in South Australia’s history, with two majorities within a total of four terms held over 16 years (Williams & Galicki, 2017).

South Australia's economy was a central priority of the Labour government during the first 10 years of its HiAP initiative. Ilona Kickbusch was instrumental in fostering its sustained implementation, having highlighted the significant role of non-health sector policies in shaping the SDoH and related population health outcomes (Baum et al., 2015). Accordingly, HiAP was proposed as a means of engaging non-health sectors in health promotion and prevention efforts (Lee et al., 2013). On a broader level, Premier Rann's joined-up agenda was framed as strategy to address austerity (Baum et al., 2017). As such, health promotion and disease prevention were valued "instrumentally rather than intrinsically" (p.14) given their potential to stimulate economic productivity and reduce healthcare costs (Delany et al., 2016). Viewing health as an 'economic driver' was thus critical to HiAP's sustained implementation.

The apparent relevance and utility of HiAP was met with ongoing high-level support from various other political elites. In 2009, Prime Minister Kevin Rudd publicly critiqued the prioritization of neoliberal policies and, in doing so, "opened the agenda for greater acceptance of the importance of the social determinants of health and the opportunities represented by a HiAP approach" (Baum & Laris, 2010, as cited by Shankardass et al., 2014). In 2010, the Shadow Health Minister demonstrated bipartisan support for the initiative when he called on non-health sectors to consider the potential health impacts of their policies (Delany et al., 2017). Three years later, the loss of more than 3000 jobs within the state's automotive industry coincided with a relatively new Labour Government. Consequently, efforts to improve economic development were prioritized over many core objectives, including SASP. Despite fewer incentives to engage with HiAP, its sustained implementation is additionally attributed to "powerful public servants" both within and beyond the health realm (Baum et al., 2015, p.9). Thus, similar to the agenda setting phase, support for HiAP appeared to diffuse from the top down, resulting in a "strong philosophical agreement" surrounding intersectoral collaboration to improve the policy outputs of all government sectors (Williams & Galicki, 2017).

Jurisdiction – “how authority over political responsibility for policy issues is distributed across formally constituted bodies in government” – (Oneka et al., 2017, p.837).

The mandate for intersectoral collaboration established by the DPC provided a necessary impetus for non-health sector engagement, as clear commitment from the state’s central authority indicated that HiAP was not solely designed to benefit the health sector’s agenda, or impose related values and processes within non-health departments (Government of South Australia, 2011). This approach helped to avoid perceptions of *health imperialism* and further established the foundation for sustained implementation.

The central government mandate also enhanced the legitimacy and credibility of both the HLA process, and the related objectives of the HiAP Unit (Delany et al., 2014). In so doing, Unit staff became key drivers of sustained implementation by cultivating intersectoral relationships across traditionally siloed policy domains (Williams & Galicki, 2017). In turn, these relationships facilitated ongoing engagement with the HLA process and helped to reinforce the value of HiAP through a ‘*learning by doing*’ approach.

HiAP Unit staff employed four key strategies to build and maintain relationships across government sectors: 1) *avoid health imperialism* (e.g., work to advance non-health sector priorities while also addressing health considerations); 2) *provide operational support* (e.g., establish broad strategic visions with host departments); 3) *provide content expertise* (e.g., promote and position the role of the SDoH within non-health sectors) and 4) *facilitate ongoing networking* (e.g., build trust via transparent agendas, joint responsibility, and shared credit) (Baum et al., 2017; Delany et al., 2016; Government of South Australia, 2011). Responsibility and authority were therefore clearly demarcated for each collaborative effort.

Institutional Power – “*the ability to influence the behaviour of others to impact decisions and achieve desired outcomes.*” – (Oneka et al., 2017, p.836)

Changes to governance structures is one means of utilizing institutional power to attain ‘desired’ results (Oneka et al., 2017). Lin and Kickbusch (2017) note that mechanisms to “support and systematize” cross-sector partnerships help to ensure “ongoing action on the social determinants of health” (p.40). Within the South Australian context, this entailed aligning HiAP with evolving government objectives, thereby enhancing its relevance and utility, as follows.

South Australia’s Strategic Plan (SASP). Twenty-one targets were added to/removed from the SASP framework to better reflect the political and economic environment (Tagliaferri, 2011). Descriptions of SASP’s key priorities were also revised to emphasize a need for concerted effort (e.g., *Our Health*). Continuing to connect SASP to HiAP ensured the latter remained centered on non-health sector priorities (Government of South Australia, 2013).

Seven Strategic Priorities of Cabinet. This 2012 framework identified areas for action to support SASP’s long-term initiatives. Governance was reassigned from ExComm CEG to a group of Cabinet Taskforces responsible for each priority. Support was provided by the Chief Executives of non-health sectors whose policy objectives aligned with at least one of SASP’s seven strategic priorities (Government of South Australia, 2011). The HiAP Unit continued to conduct HLAs for each priority, which led to new opportunities for intersectoral collaboration, and strengthened relationships with decisionmakers (Williams & Galicki, 2017).

Public Health Act (2011). Enacted in 2013, the development of the Public Health Act coincided with the efforts to bring HiAP to the political agenda. Two clauses within the Act were notably aligned with HiAP’s core principles. First, the *State Public Health Plan* sought to incorporate health considerations into the policy objectives of non-health sectors (Government of South Australia, 2013). Additionally, the *Public Health Partner Authorities* section entailed a collaborative effort through which the Department of

Health and Ageing and non-health sectors engaged in health promotion and disease prevention through action on the SDoH (Williams & Galicki, 2017). As legislative lever for action, the Public Health Act was a key factor in the systematization of HiAP, thereby facilitating ongoing engagement.

Memorandum of Understanding. In 2014, the DPC and Health and Ageing renewed their 2009 Memorandum of Understanding pertaining to HiAP governance. Both the existing mandate and reporting and accountability structures were reinstated, and the central government's support reconfirmed, thereby further legitimizing HiAP (Williams & Galicki, 2017).

Public Health Partnership Branch. Later in 2014, the HiAP Unit merged into a Strategic Partnerships Team within the newfound Public Health Partnership Branch (Baum et al., 2017). While the team continued to facilitate HLA, its new priorities included the implementation of the Public Health Act (Williams & Galicki, 2017). Given the Act's legislative basis, this realignment was a key strategy for the sustained implementation of HiAP (Delany et al., 2014).

Working Together Strategy. In 2016, the government's *Working Together for Joined Up Policy Delivery* report detailed strategies to shape and prioritize intersectoral policy development, recognizing that related efforts are often hampered by "government structures, organizational culture, differing priorities across sectors, and the competitive nature of government departments" (Government of South Australia, 2016, p.5). Based on an extensive international review, the report provided 11 recommendations surrounding key elements of horizontal governance with the aim of embedding these within the public sector. The co-design and co-benefit elements of HiAP were notably prevalent throughout (Williams & Galicki, 2017).

Demonstrated Utility – Generating confidence and capacity surrounding HiAP and related processes through evidence of their causal feasibility and value, thereby establishing or maintaining buy-in

A series of evaluations further contributed to the sustained implementation of HiAP. In addition to improving its credibility and rigour (Government of South Australia, 2011), evaluation was central to the state's '*learning by doing*' approach (Delany et al., 2014). As a result, HiAP remained responsive to the needs and policy processes of non-health departments, thereby encouraging continued engagement (Buckett et al., 2011).

HiAP was supported by two evaluation processes. First, the final stage of the HLA entailed an independent review of each completed analysis. These were commissioned by the DH and undertaken by the South Australian Community Health Research Unit at Flinders University (Buckett et al., 2011). Three factors determined the overall effectiveness of each project. First, *process* evaluation explored whether the analysis met the needs of those involved, and whether a collaborative climate was established and maintained. Second, *impact* evaluation determined whether health considerations were adequately incorporated into the final policy proposal. Finally, *outcome* evaluation pertained to whether the medium-or long-term goals of the partnering non-health agency were improved, and health impacts were positive. Results were made publicly available through South Australia Health.

Early results indicated "considerable promise in achieving a shift in mindset" (Government of South Australia, 2011, p.35), with key themes including enhanced understanding of the SDoH and incorporation of related evidence into policymaking, and a positive disposition toward undertaking future HLAs (Government of South Australia, 2011). A notable caveat of these findings is that HLAs were only conducted for projects anticipated to be successful rather than those which might entail conflict or divergent policy objectives (Kickbusch et al., 2014).

The second evaluation took place as a five-year research partnership between Flinders University and South Australia Health between 2011-2016. This project examined the adoption and implementation of HiAP (i.e., *processes*), as well as its effectiveness in terms of sustained intersectoral efforts (i.e., *impacts*). Williams & Galicki (2017) note evidence of 'less tangible' processes and outcomes to have been particularly valuable to HiAP's sustained implementation. For example, one finding indicated that ongoing

exposure and engagement across government sectors led to the development of an informal Community of Practice (CoP). Through persistent efforts to champion and translate HiAP's underlying principles across policy domains, the CoP continued to “infiltrate new policy landscapes” (p.36) and contribute to its systematization.

4.6.2 Québec

The following details the political factors surrounding the adoption and sustained implementation of HIA in the sub-national province of Québec, Canada. The resultant jurisdiction-specific framework output is provided in Appendix K.

4.6.2.1 Agenda Setting

Political Culture – “*when members of a political system share the same attitudes, norms, beliefs, or values, it is characterized by a given culture*” (Oneka et al., 2017, p.837).

The Québec government has traditionally espoused a collective responsibility for population health (d'Amour et al., 2009; Gagnon & Kouri, 2008). This approach is consistent with a number of foundational health promotion frameworks, including the Lalonde Report (1976) and the Ottawa Charter (1986), which call for government-wide action on individual, social, economic and environmental determinants of health (Druet et al., 2010; Lee et al., 2013).

According to Druet et al. (2010), the ‘horizontal management’ of government policies within Québec has with time fostered a “culture of collaboration conducive to the adoption of healthy public policy” (p.94). In this regard, it is noteworthy that the province was the first in Canada to integrate health care and social services by establishing the *Ministère de la Santé et des Services sociaux* (MSSS) (i.e., the Ministry of Health and Social Services) in 1985 (Lee et al., 2013). In so doing, a socially-oriented agenda has remained prominent within Québec's largest Ministry (both in terms of size and spending), thereby facilitating ongoing action on the social determinants of health (Bernier, 2006). For example, the 1992 *Politique de la santé et du bien-être* (i.e., Health

and Wellbeing Policy) framework established intersectoral consultation as a guiding principle of the MSSS (Benoit et al., 2012), and emphasized the social determinants as the most efficient means of meeting provincial population health goals (St-Pierre et al., 2009).

Policy Elites – “actors who work within or have significant knowledge of a specific area of policy. . . outside of the government, expert advisors (e.g., former government officials) can be brought in to help plan . . . [HIA] implementation” (Oneka et al., 2017, p.836).

In June 2000, Premier Pauline Marois appointed former cabinet minister, Michel Clair, to review the provision of health and social services in Québec. Assisted by a team of eight experts within both realms, the subsequent *Clair Commission* report emphasized the value of health promotion and prevention, and explicitly recommended systematic assessment of the potential health impacts of public policies (Benoit et al., 2012).

One year later in 2001, the province’s primary public health legislation, the *Public Health Protection Act* (1972), was updated for the first time in nearly three decades (Benoit et al., 2012). A key issue with the existing Act was that it did not specify the mechanisms through which policy officials were to fulfill their health protection obligations, or where or how they could access the information necessary to do so (Bernier, 2006).

Accordingly, the MSSS established the *Group de travail sur l’élaboration de la loi sur la santé publique* (i.e., The Working Group to Amend the Public Health Act) to both amend the Act and propose new provisions (Benoit et al., 2012). To do so, the working group referenced seminal international health promotion frameworks, conducted inter-jurisdictional analyses of existing health promotion and prevention legislation and HIA initiatives, and sought to build upon the culture of intersectoral collaboration previously promoted via Québec’s Health and Welfare Policy (1992) (d’Amour et al., 2009). The new Public Health Act (2001) was adopted under the Parti Québécois government (Gagnon & Kouri, 2008), with *section 54* serving as the legal basis for Health Impact Assessment (HIA) as both a health promotion and prevention strategy (Benoit et al., 2012).

4.6.2.2 Implementation

Jurisdiction – “*how authority over and political responsibility for policy issues is distributed... across levels of government (e.g., federal vs provincial) or within a single level of government*” (Oneka et al., 2017, p.837)

Section 54 of Québec’s Public Health Act (2001) pertains to *provincial* laws and regulations (Jabot et al., 2020). Since 2002, its implementation has been overseen by the *Direction générale de la santé publique* (DGSP – i.e., the Public Health Directorate) of the MSSS (St-Pierre, 2013).

Institutional Power – “*the ability to influence the behaviour of others to impact decisions and achieve desired outcomes... actors may seek to change governance structures and use expertise to create and legitimise shared meanings and values to produce specific results*” (Oneka et al., 2017, p. 836)

Québec’s Public Health Act formally acknowledges that government laws and regulations have significant potential to affect population health and wellbeing (Bernier, 2006; Druet et al., 2010). Accordingly, *section 54* grants the Minister of Health and Social Services authority to “give other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population” (d’Amour et al. 2009, p.8). The legal basis for the development of healthy public policies therefore legitimizes health considerations within non-health sectors (Druet et al., 2010; Lee et al, 2013).

Gagnon and Kouri (2008) describe Québec’s health promotion approach as a “horizontal management” strategy in that it requires policymakers to address issues that are “no longer based exclusively on preoccupations for which they are responsible” (p.5). In this regard, the responsibilities of Québec’s health and non-health sectors are clearly defined through *section 54*:

- Subsection 1: as a government-wide advisor, the Minister of Health and Social Services possesses a *power of initiative* through which advisories may be proactively

issued to non-health ministries so as to foster healthy public policy development (Gagnon & Kouri, 2008).

- Subsection 2: non-health ministries and agencies are to assess proposed legislation and regulations for health impacts, and consult with the Minister of Health and Social Services where potentially adverse impacts are identified (d'Amour et al., 2009).

In addition to its legislative basis, the implementation of *section 54* has been supported by two key components: 1) an intragovernmental HIA mechanism; and 2) strategies to develop and transfer knowledge related to the determinants of health and healthy public policy (Diallo & Freeman, 2020). These components are intended to be mutually reinforcing (Gagnon & Kouri, 2008), as “a lack of knowledge with respect to the health impact assessment process and determinants of health were found to be the main obstacles to implementation” (Lee et al., 2013, p.20). Both have required significant resource allocation, defined by Oneka et al. (2017) as the distribution of human, informational, financial, or infrastructural resources to enhance the feasibility of implementation.

HIA. Québec’s ‘stand-alone’ HIA mechanism is consistent with the internationally-recognized conceptualization of HIA offered by the European Centre for Health Policy (WHO, 1999)⁷. Although non-health ministries⁸ must assess proposed laws and regulations and, where necessary, develop mitigation strategies, the use of HIA in particular is not mandated (Gagnon et al., 2008). Rather, as Shankardass et al. (2014) explain, “it is encouraged as a means to fulfill the requirements of the [Public Health]

⁷That is, HIA as “a combination of procedures, methods and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (WHO, 1999, p.1).

⁸ St-Pierre (2013) notes that HIA is not applied to the health sector, but rather “targets primarily those social determinants whose levers lie outside of the health sector’s responsibility” (p.13).

Act” (p.9). While assessments requirements are technically limited to proposed legislation and regulations, some sectors have over time extended this process to inform public policy development. This may be due in part to strategies to position HIA as a “positive asset” for non-health ministries (d’Amour et al., 2009, p.14).

The implementation of HIA as an intragovernmental mechanism has been supported by notable resource allocation. To begin, the MSSS established a *Network of Ministerial Representatives* comprised of members from nearly all of Québec’s provincial ministries (Gagnon & Kouri, 2008).⁹ This group was intended to raise awareness of HIA tools among decisionmakers (Benoit et al., 2012) and ensure ongoing communication with the MSSS (Lee et al., 2013). Moreover, the representatives were to provide colleagues with general information regarding the legal aspects of *section 54* and its related documentation and tools (Gagnon et al., 2008), and advise the MSSS on adjustments to improve their application (Benoit et al., 2012).

To support non-health ministries in assessing their proposals, the MSSS has also developed an HIA guide based on existing European models (Druet et al., 2010; Lee et al., 2013). Specifically, the guide identifies five stages of the HIA process to include: 1. Screening; 2. Scoping and summary analysis; 3. In-depth analysis; 4. Decision-making; and 5. Evaluation (Benoit et al., 2012)¹⁰. While its use is voluntary (Gagnon et al., 2008), the first two stages are to be conducted by non-health ministries and, where adverse effects are anticipated, the MSSS must be consulted (Benoit et al., 2012). Such instances entail a formal administrative process through which the sponsoring ministry submits a request to the General Secretariat of the MSSS, which is then forwarded to the *Direction générale de la santé publique* (DGSP – i.e., the Public Health Directorate) (St-Pierre,

⁹ Despite a strong political culture of collective responsibility for health, there has been notable reluctance within economic-and finance-oriented departments regarding HIA use (Gagnon et al., 2008; St-Pierre, 2013).

¹⁰ N. Bernier (personal communication, February 14, 2022) noted that few HIAs have been conducted according to the step-wise depiction within the HIA guide, which also had limited uptake.

2013). Finally, in light its voluntary nature, the *Ministère du Conseil exécutif* (MCE – i.e., the Ministry of Executive Council) has been described as a “watchdog of the HIA process” (St-Pierre, 2013, p.10). In particular, as a “super ministry” responsible for government-wide advice and coordination, the MCE may block projects with potentially adverse health effects, or those that should have been informed by an HIA (d’Amour et al., 2009). In such instances, proposals are rerouted to the MSSS for further review. This high-level accountability mechanism is viewed by some to foster a culture of collaboration and collective responsibility for health (e.g., Druet et al., 2010; d’Amour et al., 2009).

Knowledge Development and Transfer. The second component in place to support the implementation of *section 54* acknowledges that “multi-sectoral initiatives require knowledge and public policy explanations to be translated to a more diverse set of users who have different levels and forms of pre-existing knowledge and assumptions” (Gagnon & Kouri, 2008, p.22). Like the HIA, Québec’s knowledge development and transfer strategy has required significant resource allocation. In 2004, for example, an information bulletin was created for the purpose of disseminating to the Network of Ministerial Representatives materials related to *section 54* and the Public Health Act (Gagnon et al., 2008). Similarly, the MSSS established a public policy web portal to inform public servants of interjurisdictional healthy public policy initiatives (Benoit et al., 2012; St-Pierre et al., 2009), and funded a series of research projects alongside two major university research granting agencies – the *Fonds de la recherche en santé du Québec* (i.e., the Québec Health Research Fund) and the *Fonds Québécois de la recherche sur la société et la culture* (i.e., the Québec Research Fund for Society and Culture) (Bernier, 2006)¹¹. Related research has focused on developing impact assessment tools, and examining the health impacts of public policies (Benoit et al., 2012; Gagnon & Kouri, 2008). Together these efforts were intended to both support non-health

¹¹ As of 2022, this funding body is officially referred to as *Fonds de recherche du Québec – Santé*.

ministries in fulfilling their duties under *section 54*, and cultivate a government-wide understanding of healthy public policy (d'Amour et al., 2009).

The knowledge development and transfer strategy has also been founded upon a 2003 agreement between the MSSS and *l'Institut national de la santé publique du Québec* (INSPQ – i.e., the National Public Health Institute).¹² To support the Minister's role as government advisor, the INSPQ produces advisory notices regarding both public health issues and public policies. In each case, the subject of the advisory is identified by the MSSS, and members of the Network of Ministerial Representatives are invited to contribute via a committee comprised of directors from the MSSS and INSPQ (Benoit et al., 2012). Gagnon and Kouri (2008) explain, “the advisories demonstrate the ability to credibly document the links between health problems and certain health determinants, including those that are not bio-medical in nature” (p.17). The INSPQ has thus been integral in supporting both subsections of *section 54* (Gagnon & Kouri, 2008).

Finally, the National Collaborating Centre for Healthy Public Policy (NCCHPP) has functioned as an additional source of content expertise and technical support related to HIA. Hosted by the INSPQ since 2005, the NCCHPP's mandate includes the synthesis, translation, and exchange of knowledge pertaining to non-medical determinants of health (d'Amour et al., 2009). Its contributions to date include resources related to the theory and practice of HIA (Benoit et al., 2012), as well as HIA background information, support tools, and training programs (Diallo & Freeman, 2020). The NCCHPP has thus enhanced the expertise of the INSPQ and, in so doing, furthered the objectives of *section 54* (Benoit et al., 2012).

¹² The Québec government founded the INSPQ in 1998 in an effort to integrate regional public health centers in the province's two largest cities – Montreal and Québec City. The initial aim was to consolidate and thus improve access to public health expertise (Bernier, 2006). Note that Québec employs the term “National” where other Canadian jurisdictions use the term “Provincial”.

4.6.2.3 Sustained Implementation

Institutional Power – “the ability to influence the behaviour of others to impact decisions and achieve desired outcomes” (Oneka et al., 2017, p.836)

Section 54 of Québec’s Public Health Act functions as “a lever for the systematic integration of health concerns in policies” (d’Amour et al., 2009, p.17; see also Gagnon et al., 2008). While subsection 2 requires non-health ministries to assess proposed laws and regulations for potential health impacts, neither the use of HIA nor the integration of its findings are required (d’Amour et al., 2009; Shankardass et al., 2014). In light of a desire among various sectors to comply with the legal obligations of the Act, however, HIA is positioned as an intergovernmental mechanism to assist non-health ministries in fulfilling related duties (Gagnon & Kouri, 2008; St-Pierre, 2013). Power is thus “primarily conceived as legal and constraining, even though it can also be said to be providing incentives” (d’Amour et al., 2009, p.14).

Oneka et al. (2017) highlight the use of power among *leaders* as an important factor to consider within a broader exploration of factors contributing to policy implementation. While subsection 1 of *section 54* grants the Minister of Health a ‘power of initiative to intervene on and proactively issue advisories regarding the activities of non-health ministries (Benoit et al., 2012; Diallo & Freeman, 2020), the MSSS has notably opted for a collaborative rather than “purely authoritarian” approach (St-Pierre, 2013, p.9). As such, it seeks to attain *win-win* outcomes which both respect the policy objectives of non-health sectors while simultaneously accounting for related health concerns (Druet et al., 2010; St-Pierre, 2013). This approach is supported by the technical support and expertise offered by the INSPQ, as well as ongoing knowledge development and transfer strategies through which non-health ministries may come to appreciate their health-related responsibilities (d’Amour et al., 2009). Moreover, subsection 2 of *section 54* requires that non-health ministries themselves initiate health assessments and related consultations, thereby instilling a sense of autonomy and voluntary participation (Druet et al., 2010; St-Pierre, 2013). It therefore appears that leadership within the MSSS and, more broadly, the use of institutional power, aim to avoid perceptions of *health imperialism* – that is, the

sense that the health sector is impinging on or undermining the policy objectives of non-health ministries (Oneka et al., 2017). For example, d'Amour et al. (2009) recount an instance in which the MSSS collaborated with various sectors to ensure their respective HIA guides “would reflect ministerial realities more closely and use language suitable to them” (p.17). Institutional power is thus exercised in a way to ensure continued buy-in among non-health sectors (St-Pierre, 2013).

Resource Allocation – “*human, informational, financial and infrastructural resources that can increase the feasibility of [HIA implementation]*” (Oneka et al., 2017, p.837)

The Network of Ministerial Representatives, typically comprised of policy staff from the Administrative Secretariat or the Strategic/Policy Planning Divisions of their non-health ministries (Benoit et al., 2012), has played a key role in fostering the ongoing use of HIA (Druet et al., 2012). As noted, this group has been tasked with disseminating information and resources pertaining to *section 54*, the Public Health Act, and knowledge-sharing events (Benoit et al., 2012).¹³ These efforts have occurred alongside similar awareness raising strategies of the MSSS. In 2012, for example, the Ministry’s Health Status Monitoring Division disseminated a conceptual framework of non-medical health determinants to demonstrate the links between non-health sector objectives and population health outcomes (Benoit et al., 2012). As noted by Jabot et al. (2020), “this awareness has promoted communication, outreach and legitimization of health issues within certain departments, thus facilitating the consideration of health in public policy development processes” (p.2).

Finally, both the intragovernmental HIA mechanism and knowledge development and transfer strategies have been subject to ongoing adjustments to enhance their effectiveness. Through bi-annual meetings, the Network of Ministerial Representatives

¹³ For example, the INSPQ hosts *Journées annuelles de santé publique* (i.e., “Annual Public Health Days”) – a conference for “updating knowledge, developing skills, and innovating practices” in education and public health.

has recommended to the MSSS ways to improve the application of *section 54* based on experiences within their own ministries (Benoit et al., 2012). Similarly, in 2003, the MSSS tasked a team at the *École nationale d'administration publique* (ENAP – i.e., Québec School of Public Administration) with exploring the receptivity to and extent of HIA implementation within non-health ministries (Benoit et al., 2012). ENAP was commissioned again to assess how and to what extent HIA had resulted in various process-related changes at the individual, group, organizational and inter-organization levels, as well as how any positive changes might be sustained (St-Pierre, 2013). According to d'Amour et al. (2009), while it is difficult to gauge the direct population health impact of HIA, assessment of its potential to influence policy-related decisions and raise awareness of health determinants among decisionmakers is viewed by some as “a key aspect of promoting and encouraging the acceptance of the practice” (p.19).

4.6.3 Synthesized Framework

	South Australia	Québec
Agenda Setting	Policy Elites	
	Kickbusch advocated for intersectoral policy approach; the proposed application of “health lens” (i.e., HLA) to South Australia’s Strategic Plan (SASP) targets entailed a ‘win-win’ strategy to secure cross-sectoral and high-level buy-in.	A working group commissioned to review health and social services in QC recommended assessing policies for potential health impacts; a second working group subsequently revised the province’s public health legislation, introducing <i>Section 54</i> as the legal basis for Health Impact Assessment (HIA)
	Political Culture	
	Shared sense of urgency due to “budgetary crisis” stemming from escalating healthcare costs; SA government historically	Shared responsibility for health across government consistent with seminal health promotion frameworks; integration of

	receptive to policy collaboration and innovation.	health and social services (i.e., the Ministry of Health and Social Services - MSSS) established a longstanding socially-oriented health agenda, thereby facilitating ongoing action on the SDoH.
Implementation	Jurisdiction	
	Efforts to preserve existing policy jurisdictions key to avoiding <i>health imperialism</i> & maintaining HiAP buy-in; Department of Health (DH) positioned as <i>facilitators</i> rather than <i>owners</i> of HiAP initiative, with focus given to <i>win-win</i> strategies. Use of existing interconnected governance structures critical to legitimizing shared values across sectors (i.e., Institutional Power) and further maintaining policy jurisdictions; Key governance structures: MOU “ExComm”/ “ExCommCEG”; and a HiAP Unit.	Section 54 is limited to laws and regulations at the provincial government level; its enactment is overseen by the public health directorate of the MSSS.
Sustained Implementation	Institutional Power	
	Ongoing changes to existing governance structures has aligned HiAP with evolving government objectives, including renewal of the 2009 memorandum of understanding, revision of existing SASP targets, and the dissolution of the HiAP unit. Doing so has thus maintained its relevance.	The <i>power of initiative</i> granted to the Minister of Health and Social Services entails a collaborative win-win approach rather than authoritative imposition, thereby instilling a sense of autonomy and voluntary participation among non-health sectors

4.7 Discussion

The present study provides an in-depth exploration of the political factors surrounding the adoption and sustained implementation of HIA in Québec and HLA in South Australia. Despite the contextual nature of the design and application of health impact tools (Bernier, 2006), a synthesis of policy or program elements, as implemented in two or more regions, may be of use to “emulators” pursuing similar approaches (Dolowitz & Marsh, 1996). Indeed, as Kickbusch and Buckett (2010) previously concluded, “early results from both [Québec] and [South Australia] indicate that there may be a broader set of values, principles and approaches that can have extensive application across a range of government and country contexts” (p.100). Findings from the present exploration, derived from a more recent collection of various literature types, confirm the authors’ earlier observations to some extent. In this regard, the Framework Analysis method has proven useful in developing frameworks specific to Québec and South Australia, as well as facilitating the synthesis of these findings to produce a final integrated framework. Given the general lack of health impact tool use among Canada’s provincial governments (Linzalone, 2018), both the jurisdiction-specific and synthesized findings may serve as useful blueprint for advocates (i.e., “emulators”) operating either within or beyond government.

The political factors identified by Oneka et al. (2017) were generally supported by the case articles. As a notable exception, the literature surrounding HIA and HLA use appears to largely overlook the role of a ‘*political support*’ component – that is, “citizens’ acceptance or rejection of particular governments...[which] can influence the length of HiAP and the type of HiAP” (p.837). While this highlights a possible area for future research, it might also reflect the literature search strategies employed. Moreover, as the most significant revision to the original glossary, the removal of the ‘political agenda’ component from the three framework outputs should also be noted. Rather, the case articles of both regions provided information rich enough to demarcate three stages of HIA and HLA use – that is, agenda setting, implementation, and sustained implementation. The original glossary was thus useful in guiding attention to the

interrelated political factors respective to each stage, thereby facilitating the development of three comprehensive evidence-informed frameworks.

The minimal overlap in the respective approaches to HIA and HLA implementation suggests that the design and application of these tools are indeed idiosyncratic to their political and administrative contexts (Kickbusch & Buckett, 2010; McCallum et al., 2015; Shankardass et al., 2014). Accordingly, Bernier (2006) concludes, “when communities build public health strategies for addressing the [SDoH], they should tailor them to specific administrative arrangements and cultures, rather than search for examples to emulate” (p.35). However, the present exploration of health impact tools at least provides HIA proponents with detailed starting points from which said strategies may be tailored. This is arguably valuable given the paucity of political thinking within the public health realm (Fafard, 2013; Gagnon et al., 2017; Oneka et al., 2017). Moreover, a noted benefit of the *hybridization and synthesis* approach to policy transfer is the option to select those programmatic elements deemed most feasible within emulator regions (Dolowitz & Marsh, 1996). The following four shared factors surrounding HIA and HLA implementation may therefore serve as a useful blueprint for impact assessment proponents.

The first precursor to securing health impact tools on the political agenda was *political culture*, which, according to Oneka and colleagues, pertains to guiding principles about “the proper functioning of politics” (p.837). Whereas South Australia had historically adopted intersectoral approaches to health promotion, Québec had taken the innovative step of integrating public health functions into the Ministry of Health and Social Services (i.e., the “MSSS”). Thus, both regions supported a degree of government intervention in fostering population health and wellbeing – namely, through the development and implementation of healthy public policies.

Political culture is further underscored by shared norms, beliefs, and values within a political system (Oneka et al., 2017). These may be made explicit through, for example, sector-specific mandates or broader strategic frameworks. In such instances, proponents may seek to align the adoption of health impact tools with the stated values or beliefs of

government (Breeze & Hall, 2002; Delany et al., 2014; O’Mullane, 2014; Signal et al., 2006). In South Australia, this entailed capitalizing on clear government-wide priorities by connecting HLA to an overarching framework for which there was already strong commitment. Wolman (2009) notes, however, that underlying cultural elements like values and norms are often more implicit and, as such, difficult to identify and act upon. This may be especially so for HIA proponents located beyond formal government contexts, which often operate according to discrete meso-level (i.e., organizational) norms and values (Buick, 2010; Manheimer et al., 2007; O’Mullane, 2014; Signal et al., 2006). In Québec, for example, poor HIA uptake among economically-oriented government sectors has been attributed to their “logic of productivity and profitability” (Gagnon et al., 2008, p.14). Health impact proponents might therefore consider more ‘tangible’ strategies for cultivating cultures conducive to healthy public policy, including information sessions, workshops, or training related to the SDoH, policy assessment, or HIA use in particular (Banken, 2001; Berensson & Tillgren, 2017; Breeze & Hall, 2002; Harris & Spickett, 2011).

The second shared factor that contributed to placing both HIA and HLA on the political agenda was *policy elites*. While the case articles specific to Québec offered comparatively little insight into the specifics of this component, the Public Health Act Working Group appeared to play a central role in integrating the province’s longstanding impact assessment requirement into the Public Health Act (2002). Commissioned working groups have similarly secured impact assessment tools onto political agendas elsewhere (Banken, 2001; Berensson & Tillgren, 2017).

By contrast, the role of Professor Ilona Kickbusch in fostering the use of HLA has been extensively documented since the 2008 implementation of South Australia’s HiAP strategy. However, both the circumstances surrounding her early involvement and the extent to which she ultimately shaped related outcomes remain anomalous. That is to say, her role and impact were clearly situated among a confluence of facilitative factors which may be difficult, if at all possible, to replicate. These include, for example, an existing central government commitment to a ‘joined-up’ agenda, a strategic framework for which

there was widespread government buy-in, a longstanding “budgetary crisis” requiring innovative solutions, and the ‘*Thinker in Residence*’ program as a prestigious venue through which HiAP could be endorsed. Moreover, Professor Kickbusch’s ‘*claim to hearing*’, which granted direct access to the Premier and Cabinet, afforded her rare status as both a ‘*policy elite*’ and ‘*external political elite*’. This calls to attention the highly interconnected and often contingent nature of the political factors at play, and represents a notable refinement to Oneka and colleagues’ original glossary. Nevertheless, proponents may focus on two central tenets of Professor Kickbusch’s advocacy efforts – that is, they may seek to recruit policy elites who can *frame* the use of health impact tools as an advantage to government (e.g., an “economic lever”) (Banken, 2001; Berensson & Tillgren, 2017; Delany et al., 2014; Harris & Spickett, 2011; Mattig et al., 2015) and, relatedly, identify specific *win-win* scenarios to secure initial buy-in (Signal et al., 2006). Moreover, proponents may wish to establish ongoing working relationships with high-level HIA champions who, on account of their status, may act as sounding boards for policy elites (Delaney et al., 2014).

Following agenda setting, considerations of *jurisdiction* informed the implementation of HIA and HLA as mechanisms to facilitate intersectoral collaboration in both regions. While use of Québec’s stand-alone HIA tool is not technically mandated, it is available to government sectors as a means of fulfilling the impact assessments requirements within the Public Health Act (2002). In terms of jurisdiction, its application is limited to the provincial level and overseen by the MSSS. On the other hand, the implementation of HLA in South Australia was supported by a comparatively more complex and bureaucratic strategy. Founded upon a win-win approach and efforts to avoid health imperialism, the department of health was positioned as facilitators rather than owners of the state’s HiAP initiative, of which HLA is a central component. Accordingly, its implementation was reinforced by a number of administrative elements, including a high-level mandate from central government, a memorandum of understanding, a now-defunct HiAP Unit, and the expansion of vertical reporting and accountability structures. Together these elements, aligned with what Oneka and colleagues deem *institutional power*, functioned to preserve existing jurisdictions within the state administration,

thereby securing cross-sectoral buy-in and facilitating the implementation of both HLA and HiAP. Integrating HIA/HLA into institutionalized structures and processes (i.e., ‘who does what and how’) has facilitated their implementation elsewhere, as doing so can minimize the extent of reform required to accommodate the tool’s use (Banken, 2001; Breeze & Hall, 2002; Signal et al., 2006)

Finally, the ongoing development of healthy public policies in both regions has been supported by *institutional power*, which functions to “influence the behaviour of others to impact decisions and achieve desired outcomes” (Oneka et al., 2017, p.836). In Québec, the *power of initiative* granted to the Minister of Health and Social Services under section 54 of the Public Health Act ensures that the health implications of non-health sector policies are identified and mitigation is considered. This has resulted in limited but ongoing use of the province’s HIA tool – namely, among more socially-oriented sectors. It is also noteworthy that while impact assessments were originally mandated for laws and regulations, use of the HIA tool has in some instances been voluntarily extended to proposed non-legislative policies and programs. Thus, although it has arguably been *institutionalized*, it has not attained universal buy-in. Accordingly, rather than being viewed as a panacea, a legislative approach would ideally be accompanied by political leadership (Gagnon et al., 2008) and capacity building efforts (Harris & Spickett, 2011).

In South Australia, institutional power has been employed as part of a broader multifaceted strategy to cultivate a political culture conducive to ongoing HLA use. In particular, ‘desired outcomes’ have been attained through ongoing and at times significant modifications to existing governance structures and processes. These include, for example, the 2014 renewal of the Memorandum of Understanding between the Department of Health and Premier’s Office, and updates to the sector-specific objectives within the state’s SASP framework. Exercising institutional power in each case has thus functioned to secure a degree of continued buy-in by ensuring the broader HiAP initiative remains relevant across sectors (Signal et al., 2006).

As a final consideration, the addition of a *demonstrated utility* factor should be noted. While this strategy is unique to South Australia’s approach, it was undoubtedly critical to

both securing early-buy in and ongoing commitment to both HiAP and HLA. However, as is the case with all the factors considered, its presence or absence within ‘emulator’ regions cannot be viewed as *the* deciding factor of the success or failure of policy transfer. Rather, it is important to remain mindful of their highly interconnected nature, both in terms of their influence on one another, and their roles as ‘precursors’ or ‘preconditions’ at the agenda setting, implementation, and sustained implementation stages. This is reflected in the literature surrounding HIA/HLA use internationally and, as such, care was taken to incorporate said “linkages” into the two jurisdiction-specific framework outputs.

The present exploration has highlighted possible avenues for future research. Perhaps most notably, the body of literature pertaining the use of health impact tools within sub-national government contexts appears relatively scant compared to that occurring at community or national government levels. Researchers may therefore wish to follow the leads of Québec and South Australia as two exemplary jurisdictions in which in-depth “lessons learned” have been made widely available. Moreover, there appears to be relatively little insight into the possible roles of ‘*political support*’ and ‘*ideology*’ in terms of facilitating or impeding the use of health impact tools. Future research may wish to explore these further, including how and to what extent they relate to other context-specific factors at play at the sub-national level.

4.8 Study Limitations

Findings from the present study are likely limited due to the exclusion of French-language case articles from the exploration of HIA use in Québec. Were an in-depth review of case articles published in both French and English to be undertaken, it is possible that additional insights derived may result in different framework outputs. Moreover, the policy transfer literature encourages ‘emulators’ to both consider a range of perspectives and information sources related to a particular initiative, as well as factor instances of negative outcomes or ‘policy failure’ into prospective evaluations. It is therefore noteworthy that the case articles specific to both regions were largely derived from relatively homogenous groups of researchers – some of whom have been

extensively involved in the design, implementation, and evaluation of HIA and HLA. It is perhaps for this reason that relatively few insights into any less-desirable outcomes surrounding these tools were garnered through the present exploration. Nevertheless, the sources reviewed were both relatively recent (i.e., spanning the last 18 years) and inclusive of a range of literature types (e.g., academic, grey), thereby permitting up-to-date and in-depth exploration of the initial and ongoing use of impact assessment tools within both regions.

4.9 Conclusion

While it is widely understood that the design and application of health impact tools are highly contingent upon their context of use, the present study has reconfirmed earlier observations that certain underlying factors may feasibly transcend geographic and administrative boundaries. As prospective “emulators”, health impact proponents operating both within and beyond government are encouraged to identify which of these factors may effectively inform similar initiatives within their respective jurisdictions. To do so, Framework Analysis has proven useful in facilitating in-depth exploration within single settings, as well as synthesizing “lessons learned” between cases. However, as focus on the ‘political’ elements of health impact tools will undoubtedly benefit policy transfer efforts, advocates of the political/public health nexus must ensure analytical and conceptual clarity in order to foster widespread adoption. On the other hand, emulators must remain cognizant of the highly interrelated nature of the political factors that either facilitate or impede the use of health impact tools. Rather than seeking a ‘gold standard’ approach, they may wish to use the synthesized findings derived from the present study as a useful starting point from which to tailor jurisdiction-specific strategies.

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5 Final Discussion

The following discussion briefly revisits the overall purpose of this dissertation and the key findings from each of its three integrated articles. These findings are then synthesized and presented according to any significant commonalities or differences, as well as their theoretical and practical implications. The strengths and limitations of this work are then discussed, followed by considerations of its interdisciplinary implications and avenues for future research.

5.1 Dissertation Purpose

This dissertation sought to open the “black box” of policy development in order to identify the contexts and factors conducive to implementing health impact assessment (HIA) as a required component of provincial policy development. Its three integrated articles were designed in light of an increasingly prevalent commentary regarding the need to improve the “real life” understanding of policymaking (e.g., Gagnon et al., 2017; Zardo et al., 2015) and evidence utilization (e.g., Cairney, 2016; Fafard & Hoffman, 2020) among academics, public health professionals, and health promoters. As integrating HIA into existing government processes and structures typically requires some degree of operational and institutional (i.e., norms, values) reform, it would similarly benefit HIA proponents to first understand *how* policymaking occurs, and *why* it occurs as such. Accordingly, each article focused on a specific aspect of policymaking aligned with HIA utilization – that is, intra-ministerial information seeking, inter-ministerial collaboration, and the role of political mechanisms both within and beyond ministry settings. The respective barriers and facilitators so identified provide a useful starting point from which proponents may tailor efforts to sustainably implement HIA at the provincial level.

5.2 Integrated Article Overviews & Key Findings

Chapter 1: Purposive Information Seeking within Ontario's Ministry of Education

Chapter one explored how purposive information seeking to support evidence-informed policy development has routinely occurred within a 'non-health' ministry of the Ontario government. Ontario's Ministry of Education was selected as the case of interest given its significant authority over a critical modifiable determinant of health – that is, education-based policy. As this ministry is one in which HIA use would ideally be institutionalized, this study sought to establish which *types* and *sources* of information typically inform intra-ministerial policy development, and why. To do so, senior-level public servants were positioned as 'information brokers' (Howlett & Wellstead, 2010) with significant capacity to set the parameters of education-based policy problems and their feasible solutions (Nekola & Kohoutek, 2017; Workman et al., 2009). It is at this level that the potential negative health implications of proposed public policies may initially be identified and mitigated through alternatives informed by relevant health information.

Although participants generally felt there to be few, if any, routine components of policy development within the Ministry of Education, they frequently referenced their 'due diligence' as policy staff. In this regard, their feedback consistently revealed four tasks to be undertaken across a range of contexts and circumstances – namely, 1) evidence retrieval and use, 2) consultation and collaboration, 3) policy referencing, and 4) risk analysis. Each of these are notably information-based, as has been identified elsewhere (e.g., Howlett & Newman, 2010). To begin, while education policies are expected to be *evidence-based*, participants indicated there to be no standardized approach to information retrieval (e.g., generating versus seeking) or use (e.g., proactive, iterative, or reactive). There was also notable discrepancy regarding the sources of evidence typically sought, with those in more authoritative positions relying on education-related delegations and councils, and those 'on the ground' utilizing in-house options (e.g., research branches). It is noteworthy, however, that all participants highlighted jurisdictional scans as key information sources, with some relying on selection criteria such as geographical proximity or welfare state alignment.

Similar differences regarding the second component of ‘due diligence’, *consultation and collaboration*, were also reported. Of note, staff positioned closer to the political side of the bureaucratic hierarchy were deemed “gatekeepers” of engagement, and were generally understood to possess greater inter-and intra-ministerial leeway compared to lower-level workers. As such, most participants had at least some experience with education-based *consultations*, including stakeholder engagement, expert advisors, informal networks, and intra-ministerial meetings. Conversely, those who had *collaborated* with the Ministry of Health to develop education-based policies were situated toward the top of the bureaucratic hierarchy, or within more explicitly ‘health-oriented’ branches of the Ministry of Education. Inter-ministerial collaboration was thus limited to two scenarios: *parallel track* initiatives involving shared ministerial mandates, or instances of *direct health links* requiring policy or regulatory measures to address health issues within school or childcare settings.

As the third component of ‘due diligence’, *policy referencing* was agreed to establish the foundation upon which new policies are typically developed, or existing policies updated. Participants emphasized the ‘evolutionary’ rather than ‘finite’ nature of government policy, particularly where the same political party governs multiple continuous terms.

Finally, participants highlighted the third component of ‘due diligence’, *risk analysis* as a routine approach to addressing potential negative stakeholder responses to, or public perceptions of, education-based policies. Many also highlighted the lack of systematic approaches to identifying such ‘risks’; rather, policy staff are tasked with categorizing these according to their likely occurrence and proposing mitigation strategies. This feedback reflected the required components of the Cabinet Submission template, among which *health*-related considerations are notably absent from the list of required assessments including, for example, business, economic, and financial impact.

The above four components of policy staff due diligence are conducted within a government Ministry with a clearly defined policy purview within the broader Ontario Public Service (OPS). Between 2003-2018, this purview was prescribed by three (eventually four) overarching goals related to student achievement and wellbeing. As

such, participants generally agreed on the operational utility of “allocating attention” within a policy environment underscored by time constraints on the one hand, and the need to deliver on key policy priorities, on the other. The roles and duties of policy staff, as prescribed by both the bureaucratic hierarchy and organizational structure, offered similar operational value. In this regard, each participant defined his or her responsibilities against those of political officials, and indicated that they had learned of the ‘realities’ of policymaking (i.e., “the way things are done”) through both a *learning by doing* and *mentorship* approach rather than through, for example, formal training or standard operating procedures.

Chapter 2: The Traditional Nature of Inter-Ministerial Policy Development

Chapter two explored the contexts and factors shaping the traditional nature of inter-ministerial policy development between Ontario’s health and ‘non-health’ ministries. Health and public health departments are often delegated stewards of their government’s HIA protocol (St-Pierre, 2013). Accordingly, the perceptions of Ministry of Health staff regarding their own ‘boundary-spanning’ roles, as well as the Ministry’s policy purview more broadly, were of particular interest. Exploration of the possible reasoning behind these perceptions, including longstanding formal and informal institutions, permitted additional insight into the contexts and factors that may shape future receptivity (or lack thereof) to HIA among prospective provincial stewards.

Health system services and *public health* were identified as the two predominant focus areas of Ontario’s Ministry of Health and Long-Term Care (MOHLTC) between 2003-2018. The former stems directly from the 2003 First Minister’s Health Accord, which included *healthy living* among its eight core investment areas. Accordingly, health systems services have traditionally been positioned as *complimentary* to the public health sector given its focus on secondary and tertiary care rather than primary prevention. In 2006, the creation of 14 Local Health Integration Networks (LHINs) shifted the MOHLTC into a stewardship role, with primary responsibility for the health system’s legislative landscape rather than planning and delivering healthcare services.

In similar fashion, the MOHLTC has typically overseen the strategic direction of Ontario's public health system. Per the Health Protection and Promotion Act (HPPA, 1990), the Minister sets the standards for mandatory public health programs and services via the Ontario Public Health Standards (OPHS). Local boards of health then deliver these as they align with the eight core areas of the HPPA, including *health promotion and protection*. Accordingly, Ontario's public health approach has largely entailed the provision of programs and services to prevent or ameliorate health issues, with notable emphasis on modifiable lifestyle or environmental risk factors. Although not explicitly relayed as such, this approach is conceptually aligned with the *health improvement* component of a Health in All Policies (HiAP) framework in that it addresses specific health issues within the parameters set by both the HPPA and OPHS, and according to community health status and need. This apparent mid/downstream positioning of the public health sector is noteworthy, especially in light of the province's upstream policy and legislative authority over numerous socioeconomic determinants of health.

Exploration of the MOHLTC's predominant purview established a background against which HIA-related advocacy took place in Ontario between 2003-2018. There is little indication that either HIA or HiAP have gained traction among political officials or Members of Provincial Parliament (MPPs), with the notable exception of Ontario's former Chief Medical Officer of Health. Rather, provincial HIA use has typically been espoused by prominent public health organizations, including regional health units and arms-length government agencies such as Cancer Care Ontario and Public Health Ontario. Despite some reported interest from the Ontario government (e.g., Shankardass et al., 2011), participants agreed that these and related efforts, including the Health Equity Impact Assessment (HEIA) tool developed in part by the MOHLTC, continually struggle to maintain relevance and widespread use at the provincial level.

In terms of operations at a more granular level, there was a notable discrepancy among participants as to which policy issues have traditionally fallen within the jurisdiction of the MOHLTC. In this regard, some highlighted the ministry's "social facing" initiatives (e.g., homecare services) and their frequent collaboration with "health adjacent" sectors

(e.g., the Ministry of Education). In both cases, however, the nature of inter-ministerial policy development has traditionally entailed service coordination and program delivery, with each participating ministry offering the required expertise, advice, or resources within their designated purview. Discussion of the social determinants of health (SDoH) highlighted similar divisions of labour. Specifically, participants indicated that because non-health ministries are generally understood to “own” SDOH-aligned portfolios, they are also responsible for identifying and mitigating any potential negative health implications of related policies. As a consequence, any advice or insight offered by the MOHLTC is *reactive* – that is, relegated to after-the-fact commentary unless non-health ministries seek input prior to, or during, policy development. This is of notable contrast to the nature of “health adjacent” initiatives, which typically require MOHLTC approval prior to implementation. It is also reflective of the government’s Cabinet Submission template, which requires policy staff to document the ways in which proposed policies may impact the priorities of other ministries. Participants further reiterated that health impact assessments are not a required component of the Cabinet Submission. Rather, the bureaucratic hierarchy was understood to function as a highly institutionalized “brokering mechanism” through which such considerations *might* be flagged.

Chapter 3: The Political Mechanisms Conducive to Sustained HIA Implementation

Chapter 3 explored the political factors conducive to the adoption and sustained implementation of HIA in Québec, and health lens analysis (HLA) in South Australia. As both tools have attained some degree of institutionalization within these sub-national regions, both offer exemplary cases from which “lessons learned” may be tailored within “emulator” jurisdictions. Political factors were broadly defined as “*those entered into the larger system of government which interact to influence policy-related processes and outcomes in some way.*”

Findings derived from the within-jurisdiction analyses reiterate the highly contextual nature of the design and application of health impact tools (Bernier, 2006; McCallum et al., 2015). South Australia’s approach in particular would likely be difficult to emulate given the confluence of ‘ideal’ factors and circumstances surrounding the adoption,

implementation, and sustained use of HLA. That is to say, certain entrenched mechanisms, such as political will, ideology, and political culture are unlikely to be effectively amended through short-term interventions or advocacy efforts alone. On the other hand, this case highlights the value of focusing such efforts on that which can in fact be modified. In this regard, Professor Ilona Kickbusch was undoubtedly central to securing early government-wide buy-in by linking the ‘health lens’ to state government values and priorities. From here, existing administrative structures and processes were adapted to accommodate the analysis process, with *policy learning* and *demonstrated utility* as key strategies to foster both the implementation and ongoing use of HLA. Also critical to this approach were efforts to avoid perceptions of health imperialism.

Implementation of HIA in Québec was comparatively more straightforward, with section 54 of the Public Health Act (2002) providing the legislative basis for developing healthy public policies at the provincial level. While HIA is not technically mandated, it is available to non-health sectors as a means of fulfilling the impact assessment requirements stipulated via *section 54* of the Act. Both its early implementation and ongoing use have been supported by a two-part strategy comprised of an *administrative component* (i.e., a Network of Ministerial Representatives; internal coordination and accountability mechanisms) and a *scientific component* (i.e., knowledge development and transfer; support from the National Public Health Institute [“INSPQ”] and National Collaborating Centre for Healthy Public Policy [“NCCHPP”]).

5.3 Synthesis of Key Findings

Participants from both the Education and Health ministries confirmed that the Ontario government has yet to implement health impact assessment as a required component of policy development. As prospective HIA users, policy staff within the Ministry of Education do not typically seek information for the explicit purpose of identifying and mitigating the potential negative health implications of education-based policies. Moreover, as prospective HIA stewards, Ministry of Health staff are generally unable to proactively flag the health impacts of public policies. As such, they do not routinely collaborate with non-health ministries to develop related mitigation strategies. Rather, the

operational scopes of both Ministries are prescribed by relatively unambiguous jurisdictional boundaries functioning as a ‘bottleneck of attention’ (Workman et al., 2009) more conducive to intra-ministerial objectives and priorities than a horizontal SDOH approach. Mulgan (2008) notes that while such ‘functional departmentalism’ may be highly efficient, it necessarily “skews government efforts away from activities like prevention [and] makes it harder to think systematically and see connections” (p.5)

With few exceptions (e.g., Shankardass et al., 2011), past advocacy efforts have provided little indication of how HIA may be effectively integrated into existing processes and structures of the Ontario government. Accordingly, the following synthesis of key findings provides an actionable starting point from which HIA may first be secured on the government agenda, and subsequently implemented as a required component of policy development.

Agenda Setting: A Culture of Collaboration and Policy Elites. To begin, it is important to note that despite the functional departmentalism that has persisted within the Ontario Public Service (OPS), there exists a strong culture of inter-ministerial collaboration between ministries. Similar cultures were a notable precursor to securing health impact tools on the agendas of both the Québec and South Australian governments. In both Ontario Ministries, however, the typical nature of collaboration has traditionally been limited to the co-development/delivery of programs and services, as required by shared ministerial mandates (i.e., ‘*parallel track initiatives*’). Within this scope has also existed what participants from the Ministry of Education referred to as ‘*direct health links*’, and the Ministry of Health, ‘*health adjacent*’ initiatives. These have traditionally been defined by the Ontario Public Health Standards (OPHS), which require local boards of health to collaborate with boards of education to address the health and wellbeing of those aged 0-18 in childcare or school settings. To do so, programs and services target both lifestyle and environmental factors, as stipulated via the Health Protection and Promotion Act (HPPA), so as to “promote the protective factors and address the risk factors associated with health outcomes” (MOHLTC, 2018, p.10).

As key *formal* institutions (March & Olsen, 1989), the OPHS and HPPA appeared to both reflect and reinforce the predominant and constrained understanding of ‘health’ and its antecedents among policy staff within both Ministries. Interestingly, however, the health benefits of major education-based initiatives have traditionally been recognized within education frameworks and among political officials. Similarly, the OPHS do acknowledge both the SDoH and seminal health promotion frameworks citing healthy public policies as critical determinants of health. Accordingly, there is a need to bridge this apparent praxis gap in order to expand the scope of Ontario’s public health sector from a mid/downstream *health improvement* focus to include a complementary upstream *impact mitigation* strategy. This will require a more hands-on approach at the provincial level, such that the SDoH become more proximal to the core agendas of both Ministries. Moreover, it will necessitate that they routinely extend attention beyond lifestyle and environmental health determinants to also prioritize the potential health impacts of education-based policies.

Efforts to secure buy-in at the agenda setting stage may draw from the knowledge transfer strategies employed by Québec’s MSSS which, together with the INSPQ and NCCHPP, has continuously worked to enhance the understanding of the SDoH and healthy public policies among government staff. South Australia’s similar pre-implementation ‘policy learning’ strategy included a *demonstrated utility* component to highlight the value of its proposed health lens. In Ontario, the adoption of HIA would indeed make public health *complimentary to* health system services, and proponents should seek to align its potential value with the bottom line goals of both the Ministry of Health and the government more broadly. For example, the systemic health inequities revealed by the government’s emergency response to the COVID-19 pandemic (PHO, 2020) clearly demonstrate the value of an upstream SDoH approach in enhancing the socioeconomic living conditions of all Ontarians, including traditionally vulnerable and marginalized populations. In this regard, HIA use at the provincial level would complement the health equity standard within the OPHS, which requires that local public health strategies are *responsive to* “current and evolving health conditions” and seek to “decrease health inequities such that everyone has equal opportunities for optimal health”

(MOHLTC, 2018, p.21). In the case of the Ministry of Education, HIA use could be connected to, for example, the *student wellbeing* mandate within the provincial Education Act (1990).

In light of these considerations, it is also noteworthy that findings from chapters one and two indicate ministerial mandates to be all-important. As such, HIA proponents should also focus early buy-in efforts at the executive level, especially since, as noted, top officials have traditionally recognized the health benefits of education-based policies. However, it should also be noted that over the 15-year focus of both case studies, Ontario was governed by two Liberal regimes which, despite their clear education and wellness orientations, failed to adopt HIA or a related HiAP protocol. This further reinforces the seemingly unique nature of South Australia's case, where a confluence of ideal circumstances included high-level champions among the Department of Premier and Cabinet, and the 'claim to hearing' granted to Professor Kickbusch. Thus, proponents may also wish to focus on cultivating an understanding of healthy public policies and the 'life course' approach among education stakeholders and the public, as their perceptions were identified by Ministry of Education staff as 'risk' priorities. Pressure exerted by these groups would arguably align with what Oneka and colleagues deem *political support* - that is, "citizens' acceptance or rejection of particular governments" (Oneka et al., 2017, p.837).

In addition to a culture of collaboration, policy elites were critical to securing health impact tools on the agendas of the Québec and South Australian governments. In Québec, HIA was proposed as a means of fulfilling the impact assessment requirements of the provincial Public Health Act (2002). In South Australia, Professor Kickbusch effectively linked HIA to the state's strategic mandate ("SASP"). In Ontario, policy elites within and beyond government have historically advocated for the adoption of formal HIA and HiAP without enduring success. As the primary legislation governing Ontario's public health system, future proponents may wish to propose the HPPA (1990) as a formal institution into which an HIA requirement may be integrated. Doing so would necessarily

extend HIA's application beyond the OPHS, the scope of which is limited to the community level and select government ministries.

Alternatively, requirements within the Ontario Agency for Health Protection and Promotion Act (2007) are notably aligned with the use of impact assessment tools. For example, *Object 6c* requires Public Health Ontario to “inform and contribute to policy development...within the Government of Ontario through advice and impact analysis of public health issues” (p.2). Moreover, *Object 6d* requires that it “undertake, promote, and coordinate public health research in cooperation with academic and research experts” (*Ontario Agency Act*, p.2). The Agency's role in supporting a provincial HIA protocol would thereby parallel that of the NCCHPP or South Australia's HiAP Unit. As such, it may also contribute to the earlier proposed knowledge transfer strategies to enhance government-wide understanding and ownership of the SDoH and healthy public policies. This may be especially important as, rather than functioning as a panacea, a legislative approach would ideally be accompanied by efforts to develop HIA-related capacity among policy staff (Harris & Spickett, 2011).

Implementation: Considerations of Jurisdiction. Findings from chapters one and two indicate that the bureaucratic hierarchy is viewed as a highly valuable and institutionalized component of policy development. Respondents from the Ministry of Education emphasized its utility in ensuring that each policy is informed by the necessary scope of information and, to the extent possible, accounting for the inherent uncertainties of policymaking. Similarly, those from the Ministry of Health described it as a “brokering mechanism” through which draft proposals are navigated. Nonetheless, it is important to reiterate that this process has not traditionally functioned as a means of identifying and mitigating the potential negative health impacts of public policies.

Given its perceived functionalism, HIA proponents are encouraged to work *with* the bureaucratic hierarchy rather than propose dramatic reforms to its existing structures and processes. However, this point first necessitates consideration of where within the hierarchy HIA might be most effectively integrated. For example, chapter one, which positioned policy staff as “information brokers”, confirmed earlier findings regarding

their information-based roles and responsibilities (Howlett & Newman, 2010) and, further, their potential to shape the ‘contours’ of policy issues and objectives (Nekola & Kohoutek, 2017; Workman et al., 2009). Accordingly, this appears to be an ideal level at which HIA could be applied at the outset of policy development, such that draft proposals ascending the bureaucratic “chain of command” already account for possible health impacts. Integrating HIA at this level would also address the lack of standardized risk assessment identified by Ministry of Education staff, so far as “risk” pertains to health considerations.

It is also noteworthy that those toward the ‘political side’ of the hierarchy have traditionally possessed broader intra-and inter-ministerial purviews than lower-level staff. Alternatively, it may be worth considering the appropriateness of integrating an HIA protocol at the level of Policy Committees of Cabinet, which exist to “review and consider the merits and implications of ministries’ policy proposals” (Cabinet Office, n.d., p.1). Chapter two, however, calls to attention the intentional grouping of “HESP” (i.e., Health, Education, and Social Policy) and “JEP” (i.e., Jobs and Economic Policy), which may be indicative of perceptions of ‘proximate’ policy portfolios embedded at the broader OPS level. This is especially pertinent in light of the HIA resistance observed among more economically-oriented sectors in Québec (Gagnon et al., 2008). Moreover, given that respondents from both Ministries identified Cabinet as the “last stop” in terms of policy-related decisions, it is important to consider whether the committee level is too far along in the development process to adequately account for health implications.

Both Québec and South Australia have adapted existing government structures to accommodate the use of impact assessment tools. In the former, section 54 of the Public Health Act (2002) is overseen by the Public Health Directorate while, as a “super ministry”, the Executive Council plays a critical role as an assessment “watchdog”. In South Australia, HiAP was first mandated by the Department of Premier and Cabinet and overseen by the Executive Committee of Cabinet. Both strategies have preserved the traditional policy jurisdictions between departments, thereby securing buy-in by avoiding perceptions of *health imperialism*. In Québec, the MSSS, of which the Public Health

Directorate is a part, has adopted a notably collaborative rather than ‘authoritarian’ approach by permitting non-health ministries to initiate the required impact assessment processes. On the other hand, by positioning central government as the state’s accountability mechanism, South Australia legitimized HiAP and permitted health sector entry into other departments as facilitators rather than owners of the initiative. In Ontario, it may therefore be worth granting HIA oversight to the Cabinet Office given that its traditional coordinative role has functioned to ensure that Cabinet Submissions, for which policy staff are largely responsible, have identified linkages across ministries and policies.

Sustained Implementation: Use of Institutional Power. The sustained use of HIA in Québec and HLA in South Australia has largely been supported by institutional power – that is, “the ability to influence the behaviour of others to impact decisions and achieve desired outcomes” (Oneka et al., 2017, p.836). In Québec, the ‘*power of initiative*’ granted to the Minister of Health and Social Services under s.54.1 of the Public Health Act (2002) essentially functions as a ‘safety net’ by ensuring that non-health sector policies are proactively informed by considerations of health impact. In South Australia, modifications to existing governance structures, including the state’s overarching SASP framework, have ensured that HiAP remains aligned with and relevant to evolving government objectives.

In Ontario, the likelihood of both the adoption and sustained implementation of HIA may be enhanced if it is integrated into the government’s existing Cabinet Submission tool. As another relatively institutionalized component of policy development, participants from both Ministries highlighted the direct impact of this templated process on their daily conduct, including their “due diligence” as policy staff. As such, it functions as an accountability mechanism in terms of the information sought and collaboration undertaken to support evidence-informed policy.

In navigating Cabinet Submissions through the brokering function of the bureaucracy, participants also consistently identified Cabinet as the “last stop” at which officials review and approve proposed initiatives. As such, they indicated it is at this stage that

policies are typically authorized as *good enough* rather than ideal, thereby supporting the notion of *satisficing* proposed by Simon's Bounded Rationality (1997). By integrating HIA alongside other impact assessments within the Cabinet Submission, policy staff can ensure that "good enough" is at least inclusive of health considerations. As discussed above, Cabinet Office may provide additional oversight regarding the necessary linkages between HIA stewards and users.

Finally, it is noteworthy that participants overwhelmingly indicated that they had learned of both formal and informal institutions (i.e., rules, norms, and values) through '*mentorship*' and '*learning by doing*' rather than formal OPS training. Given their clear and lasting impact on policy actor conduct, it is reasonable to anticipate that integrating HIA into existing bureaucratic structures and processes, including the Cabinet Submission, would infiltrate these pervasive knowledge transfer mechanisms. In this regard, HIA as an institution may be diffused and embedded bi-directionally. For example, its demonstrated utility at the Cabinet level would ideally establish a top-down demand that health considerations routinely inform policy development. This would to some degree reflect South Australia's high-level HiAP champions, including the Department of Premier and Cabinet. Moreover, the actual application of HIA among policy staff 'on the ground' might over time establish it as part of "the way things are done". The relative permanence of policy staff compared to their political counterparts is critical, especially as many seek to move up the bureaucratic ranks throughout their public service careers. Enacting a legislative requirement for HIA use, whether through the HPPA (1990) or OAHPP (2007), may account for the turnover of policy staff and officials alike. Collectively, such efforts are key to cultivating an environment conducive to the ongoing development of healthy public policies.

5.4 Strengths & Limitations

The sample sizes of chapters one and two are perhaps the most significant limitations of the present dissertation. The inclusion of former OPS policy staff employed between 2003-2018 also increases the possibility of recall bias, whereas feedback from all participants may have contained elements of social desirability. However, the interview

data were triangulated and confirmed with a range of policy documents, including organizational mandates, Hansard transcripts, policy frameworks, throne speeches, and procedural documents and toolkits obtained from internal sources. Moreover, there was notable consistency in the insights provided by the 17 total participants spanning two ministries. These measures suggest the findings have credible potential to provide insights beyond distinct ministries to the broader OPS level. Limitations notwithstanding, this contribution has positive implications in terms of the sub-national rather than strictly organizational focus of both the present and future research. Of final note, the integrated theoretical framework guiding both chapters was informed by two theories considered highly pertinent to bureaucratic policymaking.

The framework analysis conducted in chapter three was likely limited by the exclusion of French-language case articles. Moreover, the literature respective to both jurisdictions was relatively homogenous in terms of authorship, which is a notable limitation within policy transfer research. However, the search strategies employed for both regions were developed and refined through three separate consultations with a research librarian at Western University. Moreover, the analyzed material spanned a range of *types*, including peer-reviewed research, commentaries, and government frameworks. Doing so ensured that each framework output was informed by a broader range of up-to-date perspectives and resources than what might be possible through the inclusion of academic or grey literature alone.

5.5 Key Contributions & Disciplinary Implications

This dissertation was designed in light of an increasingly prevalent commentary regarding the need for policy research conducted at the interdisciplinary nexus of political science and public health (e.g., Gagnon et al., 2017; Greer et al., 2017; Newman et al., 2015). Explorations of purposive information-seeking and inter-ministerial policy development were guided by an integrated theoretical framework informed by the core tenets of Bounded Rationality (Simon, 1997) and Normative Institutionalism (March & Olsen, 1989). Both are considered highly pertinent to bureaucratic policymaking and

policy coordination (Peters, 1998), thereby effectively situating a public health focus (i.e., HIA and HiAP) at the crossroads of political science.

As chapters two and three sought to unpack certain elements of the policy ‘black box’, their findings contribute to an enhanced practical understanding of policymaking as it occurs in ‘real life’ policy arenas. Prominent scholars within the political science realm have previously deemed this understanding to be critically lacking among academics, health promoters, and public health professionals (e.g., Fafard & Hoffman, 2020). Together with the identification of possible HIA ‘entry points’, these findings are especially relevant to HIA proponents within these occupations. The prospective nature of this undertaking is rare within HIA literature, which tends to rely on post-hoc analyses of implementation efforts. In this regard, the present findings have also demonstrated that effectively implementing HIA requires careful attention to the different stages of the policy cycle, including agenda setting. As HIA literature often conflates “institutionalization” (i.e., ongoing use) with early implementation, related findings risk leading to ‘cart before the horse’ strategies within emulator jurisdictions.

Situating HIA against the rationalist assumptions of the oft-criticized evidence-based policy movement has important implications for the Health Information Science (HIS) discipline. Specifically, findings from chapters two and three reiterate the understanding that evidence-based policymaking is in fact inherently distinct from evidence-based medicine (Cairney & Oliver, 2017) – the latter of which remains a crux of HIS scholarship. The discrepancy between these two movements has resulted in noteworthy criticisms of the “two communities” theory (e.g., Newman et al., 2015) and, as such, it is imperative that this understanding receives equal pedagogical attention if future efforts to enhance evidence-*informed* policy are to be effective. In this regard, findings from the present research align with previous insights into both the range and scope of ‘evidence’ that typically informs policy development (Parkhurst, 2016; Sohn, 2018). However, the information-seeking focus of chapter two in particular offers a novel contribution to the HIA literature, despite the centrality of information to the assessment process. The

contexts and factors shaping information seeking within government contexts and, specifically, among non-partisan bureaucrats, has been similarly scarce to date.

Finally, the present undertaking was notably interdisciplinary, drawing upon decision-making models within cognitive science (e.g., March, 1994; Simon, 1997), the information-related implications of bureaucratic structures within public administration (e.g., Egeberg, 2003; Peters, 2015), information processing (e.g., Jones et al., 2006; Workman et al., 2009), and organizational behaviour (e.g., Christensen et al., 2020). Together with the explicit context-centric focus of this dissertation's three integrated articles, as well as the use of an integrated theoretical framework, this work is notably aligned with a "new policy sciences" approach requiring that scholars know both their policymaker *audiences* as well as the *contexts* in which they operate (Cairney & Weible, 2017). Accordingly, the present findings reconfirm Simon's (1997) notion of a "scissor with two blades", meaning that an understanding of policy actor conduct cannot be separated from their task environments. This approach has permitted the prospective identification of existing policy structures and processes conducive to HIA use in Ontario, which is especially noteworthy given the context-dependent nature of the methodological design and application of HIA (Bernier, 2006; McCallum et al., 2015).

5.6 Future Research

Findings from the present dissertation highlight several avenues for future research.

To begin, emulator regions would benefit from similar prospective evaluations of the contextual prerequisites for the adoption and sustained implementation of HIA. This will not only enhance the likelihood of effectively integrating HIA into existing government processes and structures, but also serve as valuable baselines for post-hoc analyses. The prospective focus may similarly enhance our understanding of future cases of failed HIA initiatives – the focus of which is critical to policy transfer efforts. HIA researchers are thus also encouraged to extend their focus beyond what are sometimes anomalous success stories and pay equal attention to why adoption or implementation becomes stalled or are altogether abandoned.

Future research should also focus on the demonstrated utility of HIA to enhance future buy-in among political officials. In this regard, ‘*utility*’ may be framed in terms of the bottom lines of governments, including population health outcomes and the economic benefits of HIA use.

Finally, more insight into the contexts and factors shaping routine policymaking at the sub-national government level is needed. While additional insights from non-partisan policy staff would undoubtedly enhance our current understanding, future research might also focus on higher-level staff and political officials acting as “gatekeepers” of information seeking and inter-ministerial collaboration. The integrated theoretical framework developed for the present research may be usefully extended to guide such efforts.

5.7 Conclusion

Public policy development is an inherently complex and messy process. As such, an array of information types and sources must contend with both the bound capacities of policy actors, and the embedded institutions of their task environments. HIA proponents must therefore continue to enhance their understanding of these micro-and meso-level phenomena, as well as their interactions. Combined with international “lessons learned”, these focus areas comprise a useful starting point from which jurisdiction-specific strategies to integrate HIA into existing government processes and structures may be effectively tailored.

5.8 References

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Appendices

Appendix A: Invitation Email Script, Letter of Information & Consent Form

You are invited to participate in a research study being conducted by PhD candidate, Stephanie Simpson, under the supervision of Dr. Anita Kothari, of Western University.

The purpose of this study is to explore your perceptions of how public policy development is carried out within Ontario's Ministry of Education. In particular, we would like to better understand how individual perceptions and organizational cultures contribute to policy development processes. We are also seeking insight into how policymakers come to appreciate any formal and informal rules, norms, and routines that may guide their involvement with policy formulation.

You are invited to participate in an interview based on your experience as a senior-level government employee within the Ministry of Education. The interview will require approximately one hour of your time, and may be conducted by phone at a time and place of your choosing.

Please note that this interview will not involve questions pertaining to any one policy initiative specific to the Ministry of Education, and explicit measures will be taken to ensure anonymity and confidentiality.

Your participation will contribute to an enhanced understanding of how public policy is formulated within real political settings. This understanding is central to improving both the knowledge translation and cross-ministerial efforts necessary for the development of healthy public policies.

Attached is a Letter of Information and a Letter of Consent. If you would like more information regarding this study or its conduct, please contact Stephanie Simpson at [REDACTED], or Dr. Anita Kothari at [REDACTED].

Thank you for your time.

LETTER OF INFORMATION

Study Title: Implementing Health Impact Assessment as a required component of government policymaking: A multi-level exploration of the determinants of Healthy Public Policy.

Co-Investigators:

Stephanie Simpson, PhD(c)
Health Information Science
Email: [REDACTED]

Dr. Anita Kothari, PhD
Associate Professor, Health Studies
Email: [REDACTED]

Invitation to Participate

You are invited to participate in a research study exploring the policy formulation processes specific to select Ministries of the Ontario government. In particular, we are seeking to better understand the ways in which individual perceptions and organizational contexts shape ‘routine’ or ‘standard’ approaches to developing public policies at the provincial government level. To do so, we are seeking input from Ontario government bureaucrats.

Purpose of the Letter

This letter provides you with information required to make an informed decision about participating in the study. Please read this document carefully, and feel free to ask questions if anything is unclear, or if you have additional questions or concerns. You will be given a copy of this letter to keep for your records.

Purpose of the Study

This study will explore the ways in which individual perceptions and organizational factors shape policy formulation processes specific to select ministries of the Ontario government. The aim of this study is to contribute to a broader understanding of the contexts and factors that influence the decision to adopt *Health Impact Assessment* as a required component of government policymaking.

Inclusion Criteria

An individual may be eligible for participation if he or she presently works as a bureaucrat within the Ministry of Finance or the Ministry of Education; or has previously worked as a bureaucrat within at least one of these provincial Ministries within the last 15 years. A one-year minimum employment duration within this role is required. Eligible participants must be fluent English speakers.

Exclusion Criteria

Individuals who do not presently work as a bureaucrat within one of the above provincial Ministries, or who have not done so in the last 15 years. Individuals who have held a bureaucratic position for less than one year, and who are not fluent English speakers, are not eligible for participation.

Study Procedures

Upon agreeing to participate, you will be asked a series of interview questions regarding your understanding of policy formulation as it typically occurs within your respective Ministry. This may include insight into the formal and informal mechanisms that shape this process. Interviews will be conducted in person or by phone at a time and location determined by you. You will be asked to consent to the audio recording of your interview. Each interview is expected to last approximately one hour, and will be transcribed verbatim. All personal identifiers will be removed from the interview transcript.

Possible Risks or Harms

No possible risks or harms are anticipated during participation. The interview may be stopped at any time at your request. There are neither associated costs, nor compensation, for participating.

Possible Benefits

The information you provide will contribute to a critical knowledge gap regarding the contexts and factors that shape the decision to implement health impact assessment as a required component of government policy formulation. Moreover, your insights will contribute to an enhanced understanding of how public policy is formulated within real political settings. This understanding has been recognized as central to improving both the knowledge translation and cross-ministerial efforts necessary for developing healthy public policies.

Compensation

Compensation will not be provided for participation.

Voluntary Participation

Participation in this study is voluntary. You may decline to participate altogether, or to answer any individual question(s) throughout the interview process. You are permitted to withdraw from the study at any time; should you choose to do so, you will be given the option to also withdraw any existing study data. No new information will be collected without your consent.

Confidentiality

To ensure anonymity, no identifying information will be linked to any data within future publication(s) of the study results. All data will be password protected and stored on the Western University server. All computer files will also be password protected, and data will only be accessed by members of the research team. Representatives of Western University Health Sciences Research Ethics Board may contact you or require access to your study-related records to monitor the conduct of this research. Non-identifiable data will be kept for seven years following completion of this study, and subsequently deleted from the Western University server and destroyed to maintain confidentiality. If you choose to withdraw from this study, your data may also be removed and destroyed from the database.

CONSENT FORM

Project Title: Implementing Health Impact Assessment as a required component of government policymaking: A multi-level exploration of the determinants of Healthy Public Policy.

Principal Investigator: Dr. Anita Kothari, Associate Professor, School of Health Studies, Western University, London, Ontario. Phone: [REDACTED], ext. [REDACTED]. Email: [REDACTED]

Co-Investigator: Stephanie Simpson, PhD Candidate, [REDACTED]
I agree to participate having read the Letter of Information, and the nature of the study having been explained. All questions have been answered to my satisfaction.

I consent to this interview being audio recorded: Yes No

Participant Name (please print):

Participant Signature:

Date:

Person obtaining informed consent (please print):

Signature:

Date:

Appendix B: Semi-Structured Interview Guide (Ministry of Education)

1. Please describe your educational background; your employment experience with the Ministry of Education; and the duration of your employment.
2. With regards to policy formulation, what responsibilities or goals are central to your professional role?
 - a. What are the generally accepted rules or expectations that guide your involvement in policy formulation?
 - b. How have you come to learn these generally accepted rules or expectations?
 - c. When facing new or unfamiliar policy formulation tasks, how do you know that your decisions or actions are appropriate?
 - d. Do you feel that you can deviate from the rules that guide your professional role? If yes, under which circumstances? If no, why not?
3. In your understanding, which major policy issues or problems fall within the purview of the Ministry of Education?
 - a. Generally speaking, can you describe the ‘routine’ or ‘standard’ approach to policy formulation as it occurs in your Ministry/division?
 - b. How have you come to appreciate that this is a ‘routine’ or ‘standard’ approach to policy formulation in your Ministry?
 - c. When drafting a public policy, how do you know that it is *good enough* to be moved forward?
4. To what extent do existing policies tend to guide the formulation of new policies within the Ministry of Education?
 - a. Which factors might necessitate referencing existing policies to guide the development of a new policy?
 - b. Are there perceived benefits to using past decisions or existing policies to guide the formulation of new policies? If yes, what were they?
 - c. Are there drawbacks to using existing policies to guide the formulation of new policies? If yes, what were they?
5. What is the standard approach to retrieving external evidence to inform policy formulation within your Ministry/division?

- a. How have you come to appreciate this is a standard approach to retrieving evidence?
 - b. In your understanding, why is this the standard approach to retrieving evidence?
6. In your Ministry, are the causes of policy problems typically determined? If yes, how?
 - a. [Only if 'yes' to Question 6] Generally speaking, how would you know that any uncertainty surrounding the causes of a policy problem has been sufficiently accounted for?
 - b. How might uncertainty surrounding the causes of a policy problem impact the formulation process?
 - c. In your experience, are potential unintended consequences typically identified as part of the policy formulation process? If yes, how is this accomplished?
 - d. [Only if 'yes' to Question 6c] Generally speaking, how would you know that potential unintended consequences have been sufficiently accounted for?
7. Does your Ministry collaborate or consult with the Ministry of Health and Long-Term Care as part of the policy formulation process? If yes, under which conditions or circumstances?
 - a. Does your Ministry collaborate or consult with other health stakeholders?
 - b. [Only if 'yes' to questions 7 and/or 7a] In your view, are there benefits from such collaboration or consultation during the policy formulation process? If yes, what were they?
 - c. [Only if 'yes' to questions 7 and /or 7a] In your view, are there drawbacks from such collaboration during the policy formulation process? If yes, what are they?
 - d. [Only if 'yes' to questions 7 and 7a] In your experience, have conflicting perspectives ever emerged between your Ministry and the Ministry of Health and Long-Term Care, or external health stakeholders? If yes, how might they be reconciled or negotiated?
8. In your view, what facilitates collaboration or consultation with health stakeholders?
 - a. In your understanding, what typically hinders or impedes collaboration or consultation with health stakeholders?

Appendix C: Steps to Ensure Trustworthiness

A number of steps were taken to ensure the trustworthiness of the present study (Lincoln & Guba, 1985). *Credibility* was established through purposive sampling to provide rich, experience-based insights into policy development (Saumure & Givens, 2008). This criterion was further enhanced through prolonged engagement with the interview data, which were triangulated with a range of relevant resources at the Ministry, OPS, and Government levels. Data were managed and analyzed using NVivo 12 software, and coding independently reviewed by the dissertation supervisor.

Next, the *dependability* criterion was addressed through use of NVivo 12, which established an ongoing audit trail documenting analytical ideas, directions, and decisions (Houghton et al., 2013). Self-reflexivity was also exercised from the outset of the study. Central considerations included the factors that might impact my approach to data collection and interpretation, as well as the presentation of the findings. In this regard, I remained cognizant of how my positioning within a health-oriented discipline might elicit socially desirable responses among respondents. Accordingly, I initiated each interview by reiterating the aim of my research – that is, to better understand the contexts and factors shaping policy development *as it actually occurs*. I additionally clarified that as I had not been employed within government-or policy-related positions, I was not approaching the interviews with an experience-based sense of what policy development *‘should’* look like. Moreover, although the present study was guided by two process-related theories, understanding the ‘real life’ phenomena impacting policy development required explicit consideration of discounting evidence (i.e., theory versus praxis). Respondents were thus encouraged to provide accounts of their own experiences. Focusing on discounting evidence additionally ensured that data analysis and interpretation were not strictly confined to the predetermined tenets of the integrated framework (Miles & Huberman, 1994).

Finally, as context was central to both the case study methodology and the micro-and meso-level phenomena of interest, the findings included thick descriptions of relevant contexts and data. This further ensured their *transferability*. Moreover, the results were

accompanied by direct interview quotes to allow readers to make alternative interpretations and informed decisions regarding the degree of transferability (Houghton et al., 2013).

Appendix D: Ethics Approval



Date: 25 March 2019

To: Dr. Anita Kothari

Project ID: 113692

Study Title: Implementing Health Impact Assessment as a Required Component of Government Policymaking: A Multi-Level Exploration of the Determinants of Healthy Public Policy.

Application Type: NMREB Initial Application

Review Type: Delegated

Full Board Reporting Date: April 5 2019

Date Approval Issued: 25/Mar/2019

REB Approval Expiry Date: 25/Mar/2020

Dear Dr. Anita Kothari

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed and approved the WREM application form for the above-mentioned study, as of the date noted above. NMREB approval for this study remains valid until the expiry date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

This research study is to be conducted by the investigator noted above. All other required institutional approvals must also be obtained prior to the conduct of the study.

Documents Approved:

Document Name	Document Type	Document Date	Document Version
EmailScript_Edu	Recruitment Materials	20/Feb/2019	1

EmailScript_Health	Recruitment Materials	20/Feb/2019	1
Interview_Edu	Interview Guide	20/Feb/2019	1
Interview_Health	Interview Guide	20/Feb/2019	1
LOI-LOC-Edu	Written Consent/Assent	22/Mar/2019	2
LOI-LOC_Health	Written Consent/Assent	22/Mar/2019	2

Documents Acknowledged:

Document Name	Document Type	Document Date	Document Version
Part 2 – Theoretical Frameworks for Multi-level Analysis	Supplementary Tables/Figures	20/Feb/19	1

No deviations from, or changes to the protocol should be initiated without prior written approval from the NMREB, except when necessary to eliminate immediate hazard(s) to study participants or when the change(s) involves only administrative or logistical aspects of the trial.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario. Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB. The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.

Please do not hesitate to contact us if you have any questions.

Sincerely,

Kelly Patterson, Research Ethics Officer on behalf of Dr. Randal Graham, NMREB Chair

Note: This correspondence includes an electronic signature (validation and approval via an online system that is compliant with all regulations).

Appendix E: Semi-Structured Interview Guide (Ministry of Health)

1. Please describe your educational background; your employment experience with the Ministry of Health; and the duration of your employment.
2. In your understanding, which policy issues or problems fall within the direct purview of the Ministry of Health?
 - a. Are the policy initiatives of other Ministries understood to fall within the jurisdiction of the Ministry of Health? If yes, under which conditions or circumstances?
 - b. Are there any Ministries whose policy initiatives are generally understood to fall beyond the purview of the Ministry of Health? If yes, which one(s), and why?
 - c. How have you come to understand which policy issues are or are not within the purview of the Ministry of Health?
3. Much of the literature on the social determinants of health indicates that the public policies of non-health sectors can have unintended negative impacts on population health. Does the Ministry of Health typically assess non-health sector policies for such impacts?
 - a. [If yes] To your knowledge, who within the Ministry of Health typically assesses non-health sector policies for potential negative health impacts?
 - b. [If yes] Are certain processes or tools used to assess non-health sector policies for potential negative health impacts? If yes, what are they?
 - c. [If yes] In your understanding, are impact assessments typically conducted before or after a policy is developed? What conditions or circumstances determine this?
4. Among policy actors within the Ministry of Health, is there a person, group, or Ministry primarily responsible for preventing or mitigating the potential negative impacts of public policies? If yes, who?
 - a. In your experience, is this understanding generally consistent among policy actors working within other Ministries?
 - b. How have you come to learn that this person, group, or Ministry is primarily responsible for efforts to prevent or mitigate negative health impacts?
5. Where a proposed public policy risks introducing negative health impacts, health stakeholders may suggest alternative directions or strategies. Does the Ministry of

Health typically collaborate with non-health Ministries to develop policy alternatives to prevent or mitigate potential negative impacts?

- a. [Only if 'yes' to Question 5] In such instances, who within the Ministry of Health would typically collaborate with non-health sectors to develop policy alternatives?
 - b. In your professional role, are there generally accepted rules or expectations surrounding collaboration with non-health Ministries to inform the development of policy alternatives?
 - i. [If yes] What are they?
 - ii. [If yes] How did you come to learn the rules regarding your role surrounding consultative or collaborative efforts to develop policy alternatives?
 - iii. [If no] How would you know that your input, actions, or decisions during consultation or collaboration were appropriate? (prompt: who or what would you reference for feedback?)
 - iv. [If yes or no] How would you determine that you sufficiently fulfilled your role in policy consultation or collaboration
6. In cases where proposed policies risk introducing negative health impacts, is there a standard approach to providing evidence to inform the development of policy alternatives? If yes, what are they?
- a. [If yes] How did you come to learn that this is a standard approach to providing evidence?
 - b. [If yes] In your understanding, why is this a standard approach to providing evidence to inform policy alternatives?
 - c. [If no] How would you know that your input or guidance during consultation or collaboration is appropriate?
 - d. [If yes or no] The Ministry of Health may propose evidence-based policy alternatives in an effort to mitigate negative health impacts. However, in some instances, these alternatives may interfere with the policy goals or mandates of non-health Ministries. How might you negotiate or determine which evidence take precedence in informing policy alternatives?

7. To what extent do past decisions or existing policies tend to guide the development of new policies within the Ministry of Health?
 - a. In your understanding, are there benefits or advantages of referencing existing policies to guide the development of new policies? If yes, what are they?
 - b. Within non-health Ministries, how might the perceived benefits or utility of their existing policies affect collaborative efforts to address the negative health impacts of public policies?
8. In your view, what facilitates consultation or collaboration between health stakeholders and non-health government Ministries?
 - a. What typically hinders or impedes consultation or collaboration between health stakeholders and non-health government Ministries?

Appendix F: The Policy Purview of Ontario’s Ministry of Education (2003-2018)

McGuinty Government (2003-2013)

In 2003, the Ontario Liberal Party won a majority government under the leadership of Dalton McGuinty, whose election platform prioritized substantial reforms to Ontario’s public education system. Shortly thereafter, McGuinty highlighted two ‘disturbing trends’ motivating these efforts. First, nearly half of the students entering grade 9 either were not graduating from high school, or were not pursuing post-secondary education, despite the increasing demand in Ontario’s job market. Second, in the eight years prior to his election, private school enrollment had increased by 40 per cent (Government of Ontario, 2004a). Accordingly, McGuinty established three overarching goals to guide the Ministry of Education’s focus: 1) *improve student achievement rates* (i.e., facilitate the greatest possible success in literacy and numeracy); 2) *close the gap in student achievement* (i.e., remove barriers to an equitable education system); and 3) *enhance public confidence* (i.e., ensure public education is the preferred choice among parents) (Fullan, 2008). Accompanying these goals were two ‘non-negotiable’ indicators of success. First, the proportion of students attaining a “B” grade (i.e., the provincial standard) in reading, writing and mathematics was to increase from 55 to 75 per cent. Second, the provincial high school graduation rate would increase from 68 to 85 per cent. In doing so, the Ontario government sought to “ensure our students are among the best educated anywhere in the world” (Ministry of Education, 2004, p.1)

Rather than imposing change from the top down, McGuinty’s education reform strategy entailed a partnership with clearly defined stakeholder roles and expectations. In particular, the Ministry of Education was tasked with developing reform policies and targets, allocating program funding and external expertise, and intervening on ‘at risk’ schools. The province’s regional boards of education were responsible for hiring school staff and supporting continuous learning within school settings. While the reform mandate was established at the top, “there was a clear recognition that it was at the school level in which change had to happen” (OECD, 2012, p.138).

In 2004, Ontario's *Vision for Excellence in Public Education* established 'whole system reform' as the top priority of the McGuinty government. Accordingly, the framework outlined a series of strategies that were notably aligned with a recent collective bargaining agreement. These included, but were not limited to, capping class sizes to 20 students from junior kindergarten to Grade 3, revising curriculum to focus on literacy and numeracy, and establishing expert "turnaround teams" for struggling schools (Ministry of Education, 2004). This same year, the government allocated more than \$2 billion to improve the conditions and sustainability of public schools (Government of Ontario, 2004b).

One year later, the government implemented *Ontario's Education Advantage* (2005) as a "key social and economic policy" to improve student achievement (Government of Ontario, 2005a, p.1) This policy was guided by a series of frameworks detailing strategies for change across four distinct age cohorts: Preschool (*Best Start*), Junior Kindergarten to Grade 6 (*Every Child*), Grades 7-12 (*Student Success*), and Postsecondary school (*Reaching Higher*). As an example, one student achievement strategy saw the Ministry of Education introduce legislation to move the high school dropout age from 16 to 18 years old. In so doing, options other than classroom learning were established to encourage ongoing education. For example, the province's *Specialist High Skills Major* program permitted students to attain a high school diploma through apprenticeships or work placements in areas such as business or construction (Government of Ontario, 2005b). These and similar initiatives continued to be implemented following the 2007 general election through which Premier McGuinty won a consecutive majority government.

In April 2009, the *Equity and Inclusive Education Strategy* was implemented as part of the government's commitment to 'close the gaps' in student achievement. To help students and educators address discrimination-related barriers to education, the strategy guided regional school boards in: 1) incorporating equity and inclusivity principles into curriculum; 2) implementing and monitoring equity and inclusive education policies; and 3) keeping these up-to-date through students, staff, and parent engagement (Government

of Ontario, 2009). Later this year, the *Student Achievement and School Board Governance Act* explicitly mandated student achievement as the top priority for school boards. Ontario's Education Act (1990) was subsequently amended to specify the role of the Ministry in achieving the three overarching goals of *enhancing student achievement*, *closing the gaps*, and *maintaining public confidence* (Education Act, 1990).

In his 2010 Throne Speech, Premier McGuinty identified healthcare and education as “the most important public services for Ontario families” (Government of Ontario, 2011). Ongoing reforms to the public education system were therefore identified as a vital strategy to progress the government's economic agenda. For example, this same year, the Ministry of Education initiated the phased introduction of full-day kindergarten for four- and five-year olds across the province. In so doing, the Ontario Institute for Studies in Education (OISE) anticipated that this investment would “provide a greater economic benefit than any other sector of the Ontario economy” (Government of Ontario, 2010a). Elsewhere, the government noted the benefits of a robust public education system to extend beyond the physical and mental well-being of individuals to include “increased citizen participation within communities, as well as higher and sustainable rates of employment” (Government of Ontario, 2004b). Thus, the McGuinty government's education policies were often clearly framed as levers for Ontario's future economic prosperity.

In March 2012, the government reported that after nearly a decade of reform efforts, the province's high school graduation rate had increased 14 percentage points from 68 to 82 per cent (Government of Ontario, 2012a). Over this same period, the percentage of students in Grades 3 and 6 meeting the provincial standard in reading and math increased from 54 to 69 per cent (Government of Ontario, 2012b). In 2013, McGuinty resigned from his role as Premier and was subsequently replaced by Kathleen Wynne as interim leader until the 2014 general election.

Wynne Government (2014 – 2018)

In 2014, the Ontario Liberal Party won a majority government under the leadership of Kathleen Wynne. Having served as Minister of Education for three years between 2006 – 2010, Premier Wynne remained highly committed to progressing the education agenda established under the former Liberal government. To do so, the Ministry of Education implemented its renewed policy framework, *Achieving Excellence* (2014), with the explicit aim of “building on the gains made in education over the past 10 years” (Government of Ontario, 2014a). Specifically, it recommitted to *increasing student achievement, closing the gaps, and enhancing public confidence*, while also focusing on *promoting well-being* as a fourth distinct goal. This additional component was deemed a “watershed development” that would “broaden the learning focus ... to the whole child, both academically and socio-economically” (p.1).

In September 2014, a public mandate letter addressed to the Minister of Education identified the implementation of *Achieving Excellence* as the Ministry’s top priority (Wynne, 2014). Although similar direction had previously been specified through the 2009 amendment to Ontario’s Education Act (1990), the public nature of Wynne’s ministerial mandate letters was intended to enhance government transparency and accountability.

While the inherent personal benefits of high-quality education were generally acknowledged by the Wynne government, related policy initiatives were often explicitly linked to a broader economic agenda. This is consistent with the framing mechanisms employed by the former McGuinty government. For example, in a series of Ministry overview and mandate documents published from 2008-2011, education system improvements were positioned as a means of “ensuring the long-term success of the province’s economy” (e.g., Ministry of Education, 2008, p.2). Subsequent versions of these mandates indicated, “the overall skills and knowledge level of Ontario’s students must continue to remain competitive in a global economy” (e.g., Ministry of Education, 2013, p.4). Moreover, a newsroom brief accompanying the 2014 implementation of the *Achieving Excellence* framework declared, “supporting a world-class education system is

part of the government's economic plan that is creating jobs for today and tomorrow" (Government of Ontario, 2014a, p.1). Finally, in a 2016 mid-term mandate letter, Premier Wynne called on the Minister of Education to "update curriculum and assessment practices for teaching global competencies necessary for the current and future economy" (Wynne, 2016, p.1).

Several of the province's key education reform initiatives were successfully completed under the Wynne government. For example, four years after its launch, Ontario's full-day kindergarten initiative was fully implemented in 2014. As such, nearly 265,000 children aged four and five were enrolled in the program which, at the time, was the only of its kind in North America (Government of Ontario, 2010b). Moreover, by May 2016 the government announced that it had surpassed its goal of increasing the high school graduation rate from 68 to 85 per cent. One year later, this rate was reported to have reached 86.5 per cent (Government of Ontario, 2016b).

Appendix G: The Health & Wellbeing Purview of Ontario’s Ministry of Education

*Childcare and Early Years (Aged 0 – 12 years)*¹⁴

In Ontario, responsibility for the health and wellbeing of children up to 12 years of age was transferred from the Ministry of Children and Youth Services to the Ministry of Education in 2010. In the following years, a number of reforms to the province’s childcare and early years policies and programs sought to establish a better integrated system, support transitions for children and families, and secure the necessary foundations for education and lifetime success (Government of Ontario, 2010b). For example, in 2010 the McGuinty government initiated the implementation of a full-day kindergarten option for children aged four and five (Ministry of Education, 2010). Phased in over four years, this program entails both play-based and structured learning led by one teacher and one early childhood educator per classroom. In addition to better preparing children for their transition into the education system, it was anticipated that full-day kindergarten would help them to develop socially and emotionally through regular engagement with peers and educators (Government of Ontario, 2010c). As such, this initiative remained a top priority of the Liberal government until its full implementation in 2014 (Wynne, 2014). At this time, approximately 265,000 children across 3600 schools were enrolled in the program, which was deemed the “single most significant investment in education in a generation to provide every 4-and 5-year-old with the best possible start in life” (Government of Ontario, 2010c, p.1).

In 2014, the Ministry of Education released *How does Learning Happen? Ontario’s Pedagogy for the Early Years* as a professional guide for those working with children and families through licensed childcare centres. As a central component of the province’s early years sector, the pedagogy was built upon the *Early Learning for Every Child*

¹⁴ The Child Care and Early Years Act (CEYA, 2014) defines a ‘child’ as a person younger than 13 years of age. Cohorts within this group include: *Infants/Toddlers* (>2 years); *Preschool* (2-4yrs); *Kindergarten* (5-6yrs); and *Primary/Junior* (7-12).

Today (ELECT) framework (2007) and the *Ontario Early Years Policy Framework* (2013) – both of which prioritize positive early childhood experiences as a crucial foundation for lifetime learning, health and wellbeing (Ministry of Education, 2014a). Accordingly, the 2014 guide highlights four approaches to cultivate positive early experiences, including: 1) ensuring a sense of *belonging* (i.e., connectedness to others); 2) fostering *wellbeing* (i.e., physical and mental health); 3) facilitating *engagement* (i.e., play-based inquiry to become familiar with surroundings); and 4) encouraging *expression* (i.e., opportunities to be heard and to listen). (Ministry of Education, 2014a). To ensure optimal learning, each of these four approaches coincide with distinct goals for both children and program providers.

Finally, in 2015, the *Day Nurseries Act* (1946) was replaced by the *Child Care and Early Years Act (CCEYA)* (2014) as Ontario’s first new childcare legislation in nearly 70 years. This modernization effort sought to enhance the care and protection of children aged 0-12 through updated regulations surrounding licensing, inspections, programs and service planning, and administrative penalties. For example, in August 2015, the maximum number of children permitted in an unlicensed home-based childcare context changed from five under the age of 10 (excluding provider’s own children) to six under the age of 13 (including provider’s own children under age four) (Jones, 2014). The Ministry of Education also assumed greater authority in both monitoring and enforcement of this and similar regulations. Together with Ontario’s early years pedagogy, the CCEYA was designed to “strengthen the quality of programs and ensure high quality experiences that lead to positive outcomes in relation to children’s learning, development, health and wellbeing” (Sandals, 2014, p.1).

Kindergarten, Elementary and Secondary (Aged 4 - 18 years)

The health and wellbeing of children and youth enrolled in Ontario’s public education system are addressed through a range of policies, regulations, programs, and services. While their development and implementation have traditionally fallen within the shared

purview of Ontario’s Ministry of Education and 36¹⁵ regional boards of health, advocacy groups have effectively shaped the province’s school-based health promotion approach over time. For example, since 2000, the Ontario Healthy Schools Coalition (OHSC) has highlighted the benefits of a *Healthy Schools* approach, which is defined by two key components. First, it focuses on a holistic conception of health by promoting the physical, mental, social and spiritual wellbeing of both students and school staff. Second, it emphasizes ongoing strategies to strengthen schools’ capacities as ‘health settings’, recognizing that “school environments can create conditions that will lead to good health and optimal learning” (OHSC, 2005, p.3). A *healthy school* is thus understood to positively influence several determinants of health that extend beyond childhood and youth into adulthood (OHSC 2005). Table 1 outlines how the healthy schools approach aligns with the foundational components of the Ottawa Charter for Health Promotion (1986).

Table 1: Foundations of the *Healthy Schools* Approach

Ottawa Charter (1986)
Education is a <i>prerequisite</i> for health. The core components of health promotion include: 1) Building Healthy Public Policy; 2) Creating Supportive Environments; 3) Strengthening Community Action; 4) Developing Personal Skills; and 5) Reorienting Health Services
Healthy Schools (2000)
Foster a sense of belonging and support among school students and staff through: 1) Non-punitive policies; 2) Effective classroom management; 3) Staff wellness; and 4) Student & parent engagement

¹⁵ Ontario operated with 36 boards of health until 2018, when this number was reduced to 34.

Parallel Initiatives
Health Promoting Schools (WHO, 1997)
Comprehensive School Health (Joint Consortium on School Health, 2008)

In 2000, Ontario had 36 regional boards of health which, through the Mandatory Health Programs and Services Guidelines (MHPSGs), were mandated by the Minister of Health and Long-Term Care¹⁶ to partner with schools and school boards to implement targeted, topic-specific health promotion programs within institutional settings (e.g., sex education curriculum for grades 7-9). This same year, the OHSC advocated for a more comprehensive approach to school-based health promotion to be adopted by the province's education and public health systems. This position was formally endorsed both provincially and federally by the Ontario and Canadian Public Health Associations, respectively (OHSC, 2016). Five years later, the OHSC called on Ontario's Ministry of Health and Long-Term Care (MOHLTC) to integrate a *Comprehensive School Health Approach* into the MHPSGs so as to "ensure that public health units allocate the resources necessary to enable the building of capacity within school communities to take their own action on health issues" (OPHS, 2005, p.10). This 'priority area for action' would require inter-ministerial coordination to achieve a common vision for school health: "unless school boards/schools are encouraged by the Ministry of Education to focus on health issues and given the resource to do so, the other sectors (health, recreation, children & youth services) will not be able to partner effectively" (p.9).

In 2006, the Ontario government introduced its *Foundations for a Healthy School* framework to establish a province-wide understanding of a comprehensive approach to student health and wellbeing. To do so, the framework detailed four key mechanisms

¹⁶ The MHPSG (now 'Ontario Public Health Standards') were published for the provision of mandatory health programs and services under Section 7 of Ontario's *Health Protection and Promotion Act (R.S.O. 1990)*.

through which health-related topics could be addressed, including 1) *Quality Instruction and Programs* (i.e., opportunities to acquire knowledge and skills for healthy lifestyles); 2) *Supportive Social Environments* (i.e., ensuring learning is a positive experience); 3) *Healthy Physical Environments* (i.e., optimal learning conditions); and 4) *Community Partnerships* (i.e., securing access to resources and services to support students and staff) (People for Education, 2013). As such, this framework was clearly aligned with the core foundations of the Ottawa Charter (1986) and the Healthy Schools approach so advocated by the OHSC.

In 2007, the MHPSGs were renewed as the Ontario Public Health Standards (OPHS) and enacted in 2009 as a key component of the MOHLTC's 10 Year Strategic Plan. Unlike previous iterations, the OPHS required boards of health to partner with schools and school boards to apply a *comprehensive health promotion approach* to develop and implement healthy policies, and create supportive environments to address a range of health-related objectives (e.g., healthy eating, healthy weight, tobacco control) (MOHLTC, 2008). This same year, Ontario's *Education Act* (1990) was amended to explicitly acknowledge for the first time the role of the Ministry of Education and school boards in enhancing the *well-being* of students in the publicly funded education system (Ontario Government, 2009). Examples of the province's school-based health promotion initiatives are outlined in Table 2.

In 2011, the Ontario government introduced *Open Minds, Healthy Minds* as its comprehensive long-term strategy to reform the province's mental health system. Developed through inter-ministerial collaboration between the Ministries of Children and Youth Services, Health and Long-Term Care, and Education, one key objective focused on early identification and intervention for children and youth at risk for mental health and addiction issues. To help schools identify related signs, the province outlined three priorities, including: 1) mental health literacy and training opportunities for educators; 2) school-based programs for identification and treatment referral; and 3) up-to-date information resources in schools (MOHLTC, 2011).

Table 2: Ontario School-Based Health Promotion Initiatives between 2005-2008

Ministry of Education Overview & Mandate: <i>Health is a priority in Ontario's education system. Healthy students have demonstrated high levels of learning and skill development. They are also more likely to be healthy adults; improving their quality of life and reducing their impact on the health care system.</i>			
Initiative	Type	Year	Description
Daily Physical Activity	Policy	2005	School boards mandated to allot at least 20 minutes of physical activity per day for all students in Grades 1-8.
Sabrina's Law	Legislation	2005	School boards required to have policies and procedures in place to address anaphylaxis in schools.
Healthy Schools Challenge	Program	2006	Ontario schools challenged adopt at least one health initiative for the school year (e.g., forming a running club); those who committed received a pennant of recognition.
EatRight Ontario	Information Resource	2008	Parents and students could directly contact a registered dietician via email or telephone, or reference nutrition-related information via the EatRight website.
Trans Fat Ban	Regulation	2008	Food and beverages sold on school premises prohibited from containing higher than the prescribed percentage of trans fats; Ontario's <i>Education Act</i> (R.S.O 1990) subsequently amended to specify this rule.

In 2014, the Foundations for a Healthy Schools Framework was revised and integrated as a key resource to support student wellbeing as a key priority introduced by the Wynne government. The framework outlined five interconnected areas through which a range of health topics could be addressed, including: 1) Curriculum, Teaching & Learning; 2) School & Classroom Leadership; 3) Student Engagement; 4) Social & Physical Environments; and 5) Home, School & Community Partnerships. Each was additionally paired with sample strategies to be undertaken at the school, classroom, and student

levels. For example, to foster Student Engagement at the school level, the framework suggests using food preference surveys to determine which healthy foods to sell in cafeterias. At the student level, the framework proposes student leaderships roles in developing, organizing, and running healthy food programs such as tuck shops or breakfasts. Efforts to cultivate positive school environments and foster student wellbeing are thus expected to be undertaken within the institutional setting (Ministry of Education, 2014b).

In 2018, the OPHS were updated to include *School Health* as one of nine thematic Program Standards. Consistent with the above approaches to school-based health promotion, the revised standards clearly stated for the first time the role of Ontario's boards of health to entail "promoting the protective factors and addressing the risk factors associated with health outcomes" (OPHS, 2018, p.10). To do so would require ongoing partnerships and collaboration with school boards and schools. Accordingly, a School Health Guideline (2018) was additionally developed to assist all three stakeholders in undertaking a comprehensive health approach, and implementing health-related curricula tailored to schools' needs. The guideline includes key public health and content-specific frameworks (e.g., The Population Health Promotion Model), an overview of the roles and responsibilities of boards of health (e.g., offering support to school populations within respective public health unit jurisdictions) and required approaches (e.g., a public health program planning cycle) (MOHLTC, 2018).

Appendix H: Nine Political Factors influencing HiAP Implementation

Summarized below are the nine political factors against which case articles specific to Québec and South Australia were analyzed. Each factor has been identified in the original framework developed by Oneka et al. (2017).

Political Agenda: “the finite set of cultural, economic, and political issues that are the focus of debate and decision making within a political system; in order for Health in All Policies implementation to be successful, it must appear and remain on the political agenda” (p.836);

Political Elites: “people holding ‘authoritative positions’ who, by virtue of their privileged positions within government, tend to have regular and greater influence than policy elites; political elites have influence over the design, implementation, orientation and evaluation of Health in All Policies” (p.836);

Policy Elites: “actors who work within or have significant knowledge of a specific area of policy, and thus have significant influence over the policymaking process; the power and influence of policy elites depends on the institutional context and broader political culture in which they are operating” (p.836);

Institutional Power: “power can be understood as the ability to influence the behaviour of others to impact decisions and achieve desired outcomes. Institutional power is power exerted by governmental and non-governmental actors within institutions (e.g., labour market, education)” (p.836);

Ideology: “the set of ideas, including values and beliefs, according to which people generate normative and causal arguments about the role of states, markets, and individuals in fostering wellbeing, including health equity. The dominance of a particular ideology reflects the power and values of the group it represents, which has implications for population health” (p.837);

Jurisdiction: “how authority over and political responsibility for policy issue is distributed across formally constituted bodies in government. Jurisdictional overlap

occurs when two or more sectors of government believe they have authority over, or are responsible for, the same policy area” (p.837);

Resource Allocation: “how resources are distributed among competing demands; resource allocation decisions often involve difficult trade-offs between costs, benefits, harms and social values (e.g., equity)” (p.837);

Political Culture: “a set of guiding principles about the proper functioning and role of politics; five major components include: beliefs about authority; beliefs about group welfare versus individual interests; trade-offs between liberty versus security; the legitimacy of a political system and its leaders; and the political community” (p.837);

Political Support: “citizens’ acceptance or rejection of particular governments; political support is an important determinant of Health in All Policies implementation because it can influence the length and type of related strategies (e.g., upstream, midstream, or downstream) that a government implements” (p.838).

Appendix J: The Political Factors Conducive to Health Lens Analysis Utilization in South Australia

Agenda Setting				
Ideology	Political Culture	Political Elites	Policy Elites	Jurisdiction
SA Labour Party committed to economic recovery and business agenda; South Australia's Strategic Plan (SASP) adopted as a strategy for 'joined-up' government.	Shared sense of urgency due to "budgetary crisis" stemming from escalating healthcare costs; SA government historically receptive to policy collaboration and innovation.	'Thinkers in Residence' established by Premier Rann; Thinkers granted 'claim to hearing' in devising innovative means to proactively address SASP targets 'upstream'.	Kickbusch advocated for intersectoral policy approach; application of "health lens" to SASP targets entailed a 'win-win' strategy to secure buy-in.	Avoid health imperialism - HiAP linked to SASP to legitimize health's entry into other sectors; existing governance & accountability upheld.
		Linkages: Resource Allocation; Policy Elites; Ideology	Linkages: Ideology; Political Elites; Resource Allocation	Linkages: Political Elites; Institutional Power
Pre-Implementation				
Policy Learning				
Resource Allocation	Demonstrated Utility		Political Elites	
Rapid analyses, case studies and a HiAP conference key informational resources to secure non-health sector buy-in.	Opportunities for government actors to develop win-win strategies surrounding SASP targets, learn benefits of 'health lens' approach.		HiAP formally endorsed by the Department of the Premier & Cabinet following policy learning activities.	
Linkages: Political Elites; Policy Elites;	Linkages: Ideology; Political Culture			
Intersectoral Mechanisms				

Institutional Power			
Health Lens Analysis (HLA) as a mechanism to facilitate intersectoral collaboration; win-win strategy – SASP targets achieved via robust policies while HLA unlocks health potential		Key governance structures established to foster shared responsibility for policy initiatives, thereby enhancing HiAP buy-in: Central leadership; SASP; HiAP Unit; Priority Setting.	
Linkages: Resource Allocation; Jurisdiction; Ideology		Linkages: Ideology; Resource Allocation; Political Elites; Jurisdiction	
Implementation			
Jurisdiction			
Institutional Power			
Efforts to preserve existing policy jurisdictions key to avoiding <i>health imperialism</i> & maintaining HiAP buy-in; Department of Health (DH) positioned as <i>facilitators</i> rather than <i>owners</i> of HiAP initiative, with focus given to <i>win-win</i> strategies. Use of existing interconnected governance structures critical to legitimizing shared values across sectors (i.e., Institutional Power) and further maintaining policy jurisdictions; Key governance structures: MOU “ExComm”/ “ExCommCEG”; and a HiAP Unit.			
Linkages: Political Elites; Resource Allocation; Ideology; Political Culture			
Sustained Implementation			
Political Culture			
Political Elites	Jurisdiction	Institutional Power	Demonstrated Utility
Health positioned as a key economic driver; support for HiAP diffused from top down and endorsed by actors beyond state government.	Central government mandate critical to continued HiAP engagement & avoiding health imperialism; HiAP Unit facilitated a ‘learning by doing’ approach.	Ongoing changes to existing governance structures has aligned HiAP with evolving government objectives & thus maintained its relevance.	A series of HiAP evaluations improved its credibility and rigour, thereby facilitating ‘learning by doing’ and ongoing engagement.
Linkages: Policy Elites; Ideology			Linkages: Resource Allocation; Political Culture

Appendix K: The Political Factors Conducive to Health Impact Assessment Utilization in Québec

Agenda Setting	
Political Culture	Policy Elites
Shared responsibility for health across government consistent with seminal health promotion frameworks; integration of public health into health and social services (i.e., the Ministry of Health and Social Services - MSSS) established a longstanding socially-oriented health agenda, thereby facilitating ongoing action on the SDoH.	A working group commissioned to review health and social services in QC recommended assessing policies for potential health impacts; a second working group subsequently revised the province's public health legislation, introducing <i>Section 54</i> as the legal basis for Health Impact Assessment (HIA)
Linkage: Jurisdiction; Resource Allocation	Linkage: Institutional Power; Political Culture
Implementation	
Jurisdiction	Institutional Power
Section 54 is limited to laws and regulations at the provincial government level; its enactment is overseen by the public health directorate of the MSSS.	Resource Allocation
	Section 54 provides legal basis for developing healthy public policy, thereby legitimizing health's entry into non-health sectors; a "horizontal management" approach is supported by Section 54: subsection 1 grants the Minister of Health and Social of Services <i>power of initiative</i> ; subsection 2 places onus of responsibility for policy assessment on non-health ministries.
	HIA as an intergovernmental mechanism to assess health impacts of proposed legislation/regulations; its use has been

	supported by a Network of Ministerial Representatives; an HIA guide; and formal administrative & accountability mechanisms.
	Various knowledge development and transfer strategies to enhance understanding and capacity to support Section 54 – notably, establishment of INSPQ and NCCHP.
	Linkages: Political Elites; Jurisdiction; Political Culture;
Sustained Implementation	
Institutional Power	Resource Allocation
<p>The legal basis of Section 54 incentivizes non-health ministries to fulfill duties related to regulation/legislation assessments; the <i>power of initiative</i> granted to the Minister of Health and Social Services entails a collaborative win-win approach rather than authoritative imposition; instilling sense of autonomy and voluntary participation among non-health sectors key to ongoing engagement with assessment processes.</p>	<p>Both the Network of Ministerial Representatives and the MSSS have continued to function as key informational resources pertaining to Section 54, the Public Health Act, and knowledge-sharing events, thereby legitimizing health issues within certain departments; both the HIA tool and knowledge development and transfer strategies have been subject to ongoing adjustments to enhance their effectiveness.</p>
<p>Linkages: Jurisdiction; Resource Allocation; Political Culture</p>	

Curriculum Vitae

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