“It’s not a food issue; it’s an income issue”: using Nutritious Food Basket costing for health equity advocacy

Elaine Power¹ · Susan Belyea¹ · Patricia Collins²

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Abstract

Objectives Ontario’s public health units (PHUs) face considerable challenges in addressing the social determinants of health, even though “reducing health inequities” is a primary population health outcome in the *Ontario Public Health Standards* (OPHS). Since 1998, the OPHS mandated PHUs to use the *Nutritious Food Basket* (NFB) protocol to document food costs, a requirement that was removed in 2018. This study examined how the NFB advanced health equity advocacy by Ontario PHUs, and why some have used this tool more strategically than others.

Methods Semi-structured qualitative phone interviews were conducted with 18 public health dietitians (PHDs) and three key informants between May and October 2017. Interviews were audio-recorded, transcribed, inductively coded, and analyzed.

Results The PHDs agreed that the NFB tool provides essential localized evidence of inadequate incomes for people living in poverty, and supports the health equity mandate of PHUs in Ontario. Factors that support NFB research and advocacy work include strong PHU leadership regarding health equity, participation in community coalitions, and engagement with *Ontario Dietitians in Public Health* (ODPH). Interviewees identified lack of support at the PHU level and lack of coordination of food insecurity work at the Ministry of Health as significant barriers to PHUs’ use of the NFB to advance health equity mandates.

Conclusion This study offers compelling evidence for reinstating NFB costing in the *Ontario Public Health Standards* as a mandatory requirement of PHUs. Without this requirement, the already-limited capacity of PHUs to advance health equity in Ontario will be further compromised.

Résumé

Objectifs Les bureaux de santé publique (BSP) de l’Ontario ont des obstacles importants à surmonter pour aborder les déterminants sociaux de la santé, même si la « réduction des iniquités en santé » est l’un des trois grands résultats relatifs à la santé de la population inscrits dans les *Normes de santé publique de l’Ontario* (NSPO). Depuis 1998, les NSPO demandaient aux BSP d’utiliser le Protocole concernant le *panier à provisions nutritif* (PPN) pour établir le coût des aliments, une exigence qui a été levée en 2018. Nous avons cherché à déterminer si le PPN a favorisé le rôle actif des BSP de l’Ontario en faveur de l’équité en santé et pourquoi certains bureaux en ont fait une utilisation plus stratégique que d’autres.

Méthode Des entretiens qualitatifs semi-structurés ont été menés par téléphone auprès de 18 diététistes en santé publique et de trois autres informateurs entre mai et octobre 2017. Les entretiens ont été auto-enregistrés, transcrits, codés par induction et analysés.

Résultats Les diététistes ont convenu que le PPN est un outil essentiel, car il offre des données localisées sur l’insuffisance des revenus des personnes sous le seuil de la pauvreté et appuie le mandat de promotion de l’équité en santé par les BSP en Ontario. Les facteurs propices au travail de recherche et de promotion sur le PPN sont la force du leadership assuré par les BSP en matière d’équité en santé, la participation aux coalitions associatives et l’adhésion aux Diététistes en santé publique de l’Ontario (ODPH). Les personnes interrogées ont cité le manque de soutien aux BSP et le manque de coordination du travail sur l’insécurité

✉ Elaine Power
power@queensu.ca

Susan Belyea
belyea.s@queensu.ca

Patricia Collins
patricia.collins@queensu.ca

¹ School of Kinesiology & Health Studies, Queen’s University, Kingston, Ontario K7L 3N6, Canada

² Department of Geography and Planning, Queen’s University, Kingston, Ontario K7L 3N6, Canada

alimentaire au ministère de la Santé comme étant d'importants obstacles à l'utilisation du PPN pour favoriser le rôle actif des BSP dans le dossier de l'équité en santé.

Conclusion Notre étude présente des preuves convaincantes de la nécessité de redonner un caractère obligatoire, dans les *Normes de santé publique de l'Ontario*, au calcul des coûts du PPN par les bureaux de santé publique. Sans cette exigence, la capacité déjà limitée des BSP de favoriser l'équité en santé en Ontario ne peut que se détériorer.

Keywords Poverty · Public health · Dietitians · Health equity · Ontario · Standards

Mots-clés Pauvreté · Santé publique · Nutritionnistes · Équité en santé · Ontario · Normes

Introduction

Theoretically, the public health sector is well situated to lead multi-sector actions to address the social determinants of health (SDH). Accordingly, the *Ontario Public Health Standards* (OPHS)¹ identifies action to address the SDH as one of public health's four key domains. The OPHS require boards of health to describe the existence and effects of health inequities in local populations, and to work with community partners to decrease the health inequities that arise from the unequal distribution of the SDH. Despite this assumed role for public health, there is little documentation—and no specific direction within the OPHS—of how public health units (PHUs) might operationalize such directives.

The challenges faced by public health practitioners in working “upstream” to address the SDH and reduce health inequities have been well documented (e.g., Brassoletto and Raphael 2014; Bryant et al. 2011; Collins and Hayes 2007; McPherson et al. 2016; Raphael 2003; Raphael et al. 2015; Schrecker 2013; Sunderland et al. 2014). A recent literature review (Cohen and Marshall 2017) found no published examples of PHU-led advocacy for the most significant SDH: income. While community health centres help to fill the void to some extent in Ontario (Collins et al. 2014), the highly localized catchment areas and variability in community initiatives suggest that these are not ideal substitutes for a more standardized approach to health equity action by PHUs.

In the 2018 OPHS, the Ontario Ministry of Health and Long-Term Care (MOHLTC) omitted the protocol for the *Nutritious Food Basket* (NFB) costing—a valuable tool for health equity advocacy on poverty reduction and food insecurity. Included in Ontario public health mandates since 1998, the NFB tool calculates a standardized basket of foods that meets nutrition recommendations (adjusted for age, sex, and household composition) and reflects average Canadian food purchasing patterns (Ontario Ministry of Health Promotion 2010). To assess the *affordability* of food, public health dietitians (PHDs) deduct the calculated cost of a basket of food and

average housing costs from average household incomes from different sources (e.g., social assistance, minimum wage). In 2017 in Kingston, for example, the average monthly cost of rent for a bachelor apartment was \$694 and food for a single adult was \$283 (KFL&A Public Health 2017). These two essential costs total \$977, while total monthly income for a single adult on Ontario's social assistance program was \$794 (KFL&A Public Health 2017).

The Ontario NFB costing protocol is one of several healthy food basket costing protocols developed to assess food affordability and accessibility (Nathoo and Shoveller 2003). Dietitians have long understood that recommendations to eat a healthy diet are useless when households do not have enough money to buy groceries; for example, in the 1930s, prominent Toronto dietitian Marjorie Bell led a campaign to increase relief allowances so that recipients could afford a healthier diet (Mosby 2014). Public health nutrition practitioners and researchers in provinces and territories across the country have used food basket costing to show the cost and affordability of food (Dietitians of Canada 2008) (and see <https://proof.utoronto.ca/resources/the-nutritious-food-basket/> for a list of recent reports). In some provinces, including British Columbia (Macdonald 2009) and Nova Scotia (Williams et al. 2012), food costing activities have been used strategically for advocacy campaigns to reduce food insecurity. However, only in Ontario have PHUs been mandated by the provincial government to collect food basket costing annually.

Some PHUs in Ontario are using the evidence provided by the results of NFB costing to develop advocacy campaigns for adequate incomes. The Simcoe-Muskoka District Health Unit used their NFB analysis to become the first PHU in the province to call for a basic income in 2015 (Dunning 2015), and to launch their “No Money for Food is Cent\$less” advocacy campaign (Simcoe Muskoka District Health Unit 2017). *Ontario Dietitians in Public Health*² (ODPH) have amplified

¹ The Ontario Public Health Standards (OPHS) specify the mandatory programs and services that Ontario public health units (PHUs) are expected to deliver.

² The Ontario Dietitians in Public Health was formerly known as the Ontario Society for Nutrition Professionals in Public Health (OSNPPH). For simplicity, we refer to the organization throughout the paper as ODPH, even though some of the work we refer to was conducted when the group was known as OSNPPH.

the reach of these initiatives by endorsing a basic income guarantee to address food insecurity (Ontario Society of Nutrition Professionals in Public Health Food Security Workgroup 2015) and adopting the “Cent\$less” campaign to make food insecurity an election issue in 2018 (Ontario Dietitians in Public Health 2018).

Research relevance and study objectives

Public health matters today because it alone has a central goal of reducing health inequities—i.e., systematic, socially produced, and unjust differences in health. While the 2018 OPHS commit to reducing health inequities, there are no concomitant mandatory activities. The evidence suggests that a high-level commitment to reduce health inequities is necessary but insufficient to produce action and results.

This research fills the gap identified by Cohen and Marshall (2017) by focusing on a discrete PHU program that has clear implications for reducing poverty, food insecurity, and income-related health inequities. Before undertaking this research, we observed that some PHUs used the NFB results strategically to lobby local politicians and to educate and build capacity in local community organizations, while others simply met the minimum requirements set out by the OPHS to complete the research according to the protocol. Given these variations across PHUs, we sought to understand:

- how PHUs use the NFB costing to advocate for health equity around income,
- the value of the NFB in this work, and
- why some PHUs use it more strategically than others.

This research comes at a critical time in Ontario, for three reasons. First, the 2018 OPHS no longer mandate that PHUs perform the NFB costing, which will create even greater variability across the province in terms of local-level knowledge and ability to act regarding income inadequacy and the hardships faced by people living in poverty. Second, for the first time, Ontario opted out of measuring food insecurity on the 2015–2016 cycle of the *Canadian Community Health Survey* (CCHS), which leaves a gaping hole in public health researchers’ ability to assess the impact of public policies such as the Poverty Reduction Strategy and the recently increased minimum wage (Syal 2017). And finally, the priorities of the new Ontario government suggest that public health will need to sharpen the effectiveness of its available tools to achieve its critical goal of reducing health inequities.

Methods

We sought to interview PHDs responsible for conducting NFB costing in PHUs across Ontario. We used a purposive maximum variation sampling strategy (Ritchie et al. 2014) to ensure our sample represented a range of PHUs in terms of geographic regions and level of health equity advocacy work. We purposefully chose PHUs that did, and did not, publicly endorse *Income-related Policy Recommendations to Address Food Insecurity* (Ontario Society of Nutrition Professionals in Public Health Food Security Workgroup 2015). To these ends, we developed a purposive sample of 19 of the 36 PHUs in Ontario based on information gathered from PHU websites, the ODPH website, and professional contacts.

Nineteen PHDs were invited by email to participate in an interview. Once they agreed, they were sent a letter of information and consent form. While no one refused, ultimately one interview could not be scheduled. Thus, semi-structured, open-ended telephone interviews were conducted with PHDs in 18 of the 36 PHUs across the province, between May and October 2017. The Queen’s University General Research Ethics Board granted ethics clearance.

PHDs were asked about the value of NFB costing and the degree to which they felt supported to do health equity advocacy using the NFB research. Interviewees were encouraged to reflect on the conditions that supported their advocacy work, as well as challenges and barriers. Semi-structured interviews were also conducted with three key informants who are not PHDs but are involved in public health nutrition practice and research in Ontario. Their perspectives were sought to help understand the broader context of the potential usefulness of the NFB costing for advancing a health equity agenda in the province.

Interviews were recorded, transcribed verbatim, and coded inductively. Coding was managed using the software program ATLAS.ti. To ensure quality, we followed Tracy (2010). The first author conducted all interviews, while the second author coded all transcripts. The three authors met regularly in all phases of the research to discuss ideas, challenges, emerging themes, and interpretations. Preliminary analysis of the results was presented at the *Ontario Dietitians in Public Health 2018* annual conference and the subsequent discussion used to member check.

Results

Characteristics of the PHD sample

Ten interviewees had over 16 years of experience as PHDs, six had between 6 and 15 years, and two had 1–5 years of experience. Three interviewees were from northern Ontario, 4

from southwestern Ontario, 6 from southern-central Ontario, and 5 from eastern Ontario. Table 1 summarizes the characteristics of the PHUs represented in the sample based on their engagement in health equity work.

How NFB results get used for advocacy

All PHDs in our sample were committed to the role public health can play in addressing income-related health inequities. They spoke about the importance of being able to provide solid evidence of the inadequacy of income supports and minimum wages, and of educating the public, boards of health, and politicians about the importance of poverty as a social determinant of health. Participants identified multiple ways that the results of the NFB research are used for health equity advocacy, including:

- educating about the costs of food and housing relative to social assistance rates and minimum wages;
- building strong public health-community partnerships by signaling PHU support for poverty reduction, providing support for community organizations' funding applications, and helping community organizations build capacity for advocacy;
- supporting their boards of health to write advocacy letters to provincial ministries about the need for improved income supports to reduce food insecurity;
- supporting board of health endorsements of other health equity issues; and
- developing province-wide campaigns for health equity in professional associations and networks such as *Ontario Dietitians in Public Health* and the *alPHA-OPHA Health Equity Working Group*.

The ways in which the NFB results are used by PHDs fall into all four categories of public health advocacy strategies identified by the National Collaborating Centre for Determinants of Health (2015): (1) strategic communication and issue framing,

(2) gathering and disseminating evidence, (3) working in collaboration with community and professional groups, and (4) using the political system. However, the extent to which PHUs engaged in these activities and the range of activities in which they engaged varied considerably. A few PHDs used the results in all or almost all of the activities described above; for these PHDs, the NFB was a central tool to almost everything they did. For example, when PHD no. 10 was asked about how she used the NFB results, she replied:

I think there's a blend of being behind the scene, collecting evidence, working with researchers, if we can, but also being at the table, and present to share it at the community level, and hearing what's actually happening in communities. So, I think it's across the spectrum. (PHD no. 10)

This contrasted with another PHD, who saw the NFB costing as a discrete task, an end in itself, one of many other responsibilities. She understood her role as primarily collecting and analyzing the NFB data and writing a report:

Our role is to provide the reports and the community would advocate with that. (PHD no. 14)

Thus, while the OPHS specify that working in “partnership and collaboration” is a foundational principle for public health, how this gets interpreted and taken up differs across PHUs.

Value of the NFB tool

Interviewees described the range of ways in which the NFB costing is valuable to their health equity advocacy work. Key themes were the tool's capacity for providing stark evidence, painting a compelling local story, stimulating connections with the community, and supporting the health equity mandates of PHUs.

It provides stark evidence on the inadequacy of government-based income supports

Interviewees saw the NFB costing as a valuable indicator that objectively illustrates the inadequacy of income for those living on social assistance and minimum wages.

It's really the only tool that we have that we can use to show and advocate that the amount of money people are receiving from social assistance or people living on minimum wage just isn't enough, it's the only real tangible thing that we can say look, this is what it looks like, these are what the numbers are, to really show that there's a problem. (PHD no. 18)

Table 1 Engagement in health equity work among participating public health units in the study

Feature of PHU	Yes	No
PHU endorsed ODPH statement ^a	10	8
PHU endorsed basic income (BI) ^b	12	6
PHU endorsed <i>both</i> BI and ODPH statement	7	11
PHU engaged in advocacy in community ^a	10	8
PHU is supportive of NFB-based advocacy ^a	9	9

^a Information gathered from interviewees

^b Personal communication with the alPHA-OPHA (Association of Local Public Health Agencies-Ontario Public Health Association) Health Equity Working group

The PHDs who lobbied to get the NFB into the 1998 *Ontario Public Health Standards* knew that “crunching the numbers” would provide simple, stark, and powerful evidence. Key informant no. 2, who was familiar with the history of how the NFB came to be part of the OPHS, said that Ontario PHDs were galvanized by the 1995 election of Premier Harris to find a way to monitor food affordability in the wake of draconian cuts to social assistance. They adopted Agriculture Canada’s National Nutritious Food Basket protocol for its effectiveness in helping people understand that food insecurity “is an income issue.”

Some interviewees noted that the NFB evidence is convincing because it is based on objective market prices.

It basically turns things to fact. [Talking about lived experiences of poverty] - that only resonates with people who have emotions and empathy. (PHD no. 4)

Others commented that it provides compelling evidence of the inadequacy of social assistance and minimum wage incomes because its estimate of essential costs is so conservative:

All you have to do is put it together with housing and you’ve made a statement on basic needs that must be an underestimate of our true needs. But is a beautifully transparent benchmark against which to examine income transfers. (KI no. 1)

It paints a compelling picture about local-level poverty that drives local-level advocacy

Interviewees especially valued the *local* nature of the evidence that the NFB provides, which helps to drive locally based advocacy efforts.

What we find is that our community partners and municipalities want data that comes from as close to home as possible and that’s what makes an impact. Nothing does that as well as the nutritious food basket survey results... There’s something locally powerful about local data. ... It really helps to compel and mobilize people. (PHD no. 6)

You can say 4 million Canadians are food insecure... I will tell you what people are going to say here: “So? Tell me what the number is locally.” (PHD no. 15)

Additionally, PHDs explained that in PHUs that span diverse communities, NFB results are broken out by community because aggregated health unit data would be ignored. Thus, the results of the NFB costing were viewed as critical for

gaining attention in communities and translating provincial data into the local context.

It gives the PHU credibility with, and connections to, the community

Many interviewees identified community partnerships as an important part of their jobs, especially related to advocacy. For some PHDs, community partnerships and coalitions acted as a “work-around” in PHUs that were unsupportive of more direct health equity advocacy work.

It gave the health unit a lot of credibility within the anti-poverty movement in [city]. The fact that we were speaking out, and we were saying that income is the issue... so it was helpful...in terms of building more trust with the community. (KI no. 2)

Grassroots community organizations are...using it as part of their advocacy because they don’t have the manpower to collect that kind of evidence and ... our agency is seen as a legitimate agency so it makes it easier for them to make the case when they use it. (PHD no. 5)

The NFB reports gave PHDs a specific piece of evidence to offer their community partners, something that some organizations valued and could not produce on their own.

It supports the health equity mandate of PHUs

The PHDs who participated in this research understood the NFB to provide indispensable evidence for PHUs’ work to reduce health inequities.

Our nutritious food basket report is such a critical local piece of data that frames health equity. (PHD no. 8)

Having that cost of food basket...is a really critical piece of addressing health inequity at the health unit. And should be a critical indicator, within the context of any kind of determinants of health work that health units are doing. (PHD no. 23)

One PHD noted that when staff cuts forced her PHU to streamline operations, they began to focus on upstream policy interventions for adequate income. This PHD was confident that her PHU would continue to use the NFB protocol even when it was no longer mandatory because it was such an important piece of evidence for their advocacy work. Other PHDs were uncertain whether their NFB costing work would continue under the new standards.

Supports that facilitate the use of NFB in advocacy

The results of this study align with existing research that shows that a supportive work environment is critical in determining the weight and importance afforded to health equity advocacy work in PHUs (Cohen and Marshall 2017). Interviewees acknowledged several internal and external factors that support their health equity advocacy work.

Internal to the organization, PHDs cited the importance of support by their direct manager, board of health, associate medical officer of health, and medical officer of health. Others spoke about the importance of respectful and collaborative relationships among public health staff in general, including within-unit communication and focus. Some felt considerable support for health equity advocacy within their PHU, as exemplified by the following quote:

We have a fairly activist board of health right now. We have a medical officer of health and associate medical officer of health who are also very supportive and one, in fact, who's been a big champion for basic income guarantee. (PHD no. 5)

While internal factors were key to PHDs' ability to engage in health equity advocacy based on the NFB, dietitians also spoke enthusiastically about engaging in strong, long-term, community coalitions as key to successful advocacy work. These included regional or municipal anti-poverty– or food issue–focused coalitions. Some acknowledged the role of the PHU in helping to build and maintain these coalitions. Finally, a recurring theme in the interviews was the importance of ODPH as an invaluable source of information and support for NFB-based advocacy work.

Five years ago, 7 years ago, I might have been a lot 'oh, I don't want to upset anybody and I don't want to do something that's wrong'...and I think confidence has come from OSNPPH,³ from me really understanding...it is not about the cost, it's about the fact that people are not getting enough money. So I very freely will say that and I'm just a little bit less worried about what might happen. (PHD no. 19)

ODPH offered mentorship, evidence, and support to sometimes isolated PHDs. It offered a means for PHDs to work together to “bring forward messages that might be a challenge” (PHD no. 23). ODPH's evidence-based approach gave PHDs confidence that their work and their messages around health equity and food insecurity were accurate and important. As such, ODPH may help counter the moral distress that Sunderland et al. (2014)

have identified as a significant issue for health promoters who are working on upstream policy interventions in unsupportive environments. Many of the participants in this study were active members in ODPH; it provided an important outlet for their passion to address health inequities and promote social justice. As much as they credited their professional organization for its support of them, it was clear that the organization was strong and useful because of PHDs' own contributions to ODPH's work.

Challenges and barriers to the use of NFB in advocacy

Interviewees also considered the challenges they face in doing health equity advocacy with NFB data. These included lack of internal support, communication challenges, and the low profile of public health nutrition at the provincial level.

Lack of internal support

Some dietitians indicated that they do not receive the support they would like from various levels within the PHU for conducting NFB research and doing health equity advocacy. Some reported feelings of isolation and competition rather than collaboration across different departments within the PHU. One PHD offered the following response to whether she felt supported by her PHU in her work:

Ahh, ok well, definitely with my colleagues, I do. ... Overall my immediate management understand about the SDOH [social determinants of health]. Even up as far as the AMOH [Associate Medical Officer of Health] level...He's very much, I feel, a real ally for upstream SDOH work. Beyond him, all bets are off. (PHD no. 20)

PHDs understood that work on health equity could raise political concerns, with both the provincial government, which provides most of their funding, and the local politicians on boards of health, some of whom sought to avoid taking potentially controversial positions. Their perspectives align with researchers who suggest that some public health leaders are reluctant to engage in advocacy “to avoid upsetting the Minister” (Hancock 2015, p. E87). As a result, interviewees whose board of health or medical officer of health did not support health equity advocacy work felt muzzled in what they could say and constrained in what they could do.

Challenges of framing food insecurity as a problem of income

Another set of challenges was related to framing food insecurity as a problem of income inadequacy, and communicating income as the solution. These challenges arose within PHUs,

³ Now known as ODPH.

in communities, and with the media. Some interviewees expressed frustration that, even within their own workplaces, food-based solutions were blindly suggested as reasonable responses to food insecurity.

A few times...staff suggest we do food bank drives and they say “Oh, we should just always leave a box in the lunch room and always be doing a constant food drive” and we’re like “Oh. We really don’t feel comfortable with that.” (PHD no. 17)

The challenge of communicating the health equity message of the NFB also occurred in communication with management, including the board of health.

That’s why it’s really important to get it to the board and to start with the language that you use...[PHDs] could pair up with their health equity person, and start to look at it through that lens...don’t keep it on the nutrition [web]page...Put it on the health equity page...Move it away from food, to social determinants of health, which include income. (PHD no. 21)

Interviewees also spoke about the difficulties of communicating the link between poverty and food insecurity in the broader community. Some expressed concern that community partners were using the NFB evidence “improperly,” e.g., to support the need for budgeting lessons or food banks, rather than as evidence of the inadequacy of social assistance and minimum wage incomes.

And I see others just not quite getting it and I feel like a lot of groups I can present to again and again and again...but when we get down to what we want to do at a local level, they go back to...the food programs and community gardens. (PHD no. 9)

Many understood that a core part of their advocacy work was to educate about poverty as the cause of food insecurity.

So I share with our food policy council locally. And it brings awareness, because we are a council that’s diverse. We’ve got people who are focusing on farming and local food, and so this isn’t on their radar at all necessarily. So, for them to see it, I think is important just to raise awareness in that way. (PHD no. 10)

The predominance in the public sphere of the simple message to “feed the hungry” is a significant obstacle to “upstream” thinking about effective policy solutions to food insecurity (Power 2017). Many PHDs faced constant

struggles helping others connect the dots between food insecurity and poverty.

Low profile of public health nutrition provincially

Finally, many PHDs in our sample described a lack of support for the NFB and lack of coordination of food insecurity work at the provincial ministry level as a significant problem for health equity work. As some participants noted, Ontario is the only province or territory in Canada that does not have a designated dietitian position in the ministry responsible for public health. Without this expertise, there is no one to champion food insecurity monitoring or to ensure that protocols are prioritized and standardized across the province. For many dietitians, this is evidence of a lack of support for their health equity advocacy work.

I do know that when I had questions about the process of using the NFB, the support that comes through the Ministry has been not great... Getting responses that provide you with a clear direction has been a challenge. (PHD no. 18)

There is no dietitian champion in the Ministry who would perk up at a meeting and say ‘Wait, wait, what are you talking about? You want to skip this cycle??!’ [of measuring food insecurity on the CCHS]’ And I get it that these things, every year, look like they’re spitting out the same numbers, but that’s the whole point. (PHD no. 3)

If you’re going to be a province with nutrition related policies, for god’s sake, get yourself somebody who knows a bit about it. If you’re going to have people in the government, doing these things, why wouldn’t you hire someone who also has professional credentials?! [sounding frustrated and incredulous].... The Ontario people who came on the phone [in federal/provincial/territorial nutrition meetings] would never be interested or engaged in the conversation, because frankly, they were managers. ... They climbed the ranks; they weren’t even health professionals. (KI no. 3)

A few interviewees wondered if the lack of dietetics expertise within the MOHLTC contributed to the Province’s decision not to include the measurement of food insecurity in the 2015–2016 CCHS. One key informant wondered if the significant gap in evidence created by not including food insecurity measurement on the CCHS, followed by the omission of the NFB from the OPHS, was a result of incompetence or deliberate action to cover up the province’s lack of results in reducing poverty and food insecurity.

I think we're at a very scary place in Ontario, because we cannot see things if people turn the light out on you. And that's what's happened with the food insecurity measurement...The fastest way to end food insecurity in Canada is to stop measuring it. (KI no. 1)

Interviewees were flabbergasted that the NFB protocol would not be mandatory in the updated *Ontario Public Health Standards*, which were publicly available in draft form at the time of the interviews. They highlighted the contradiction between having health equity as a foundational standard and losing a key indicator for health equity advocacy work. When the MOHLTC issued a summary of themes raised at consultations on the draft version of the updated OPHS, the removal of the NFB protocol was highlighted as a frequent concern. The Ministry replied “The requirement to collect data on food affordability will remain in the Population Health Assessment and Surveillance Protocol; however, the use of a specific tool will not be mandated” (MOHLTC 2017, p. 20). The Ministry further elaborated that it had “received feedback from public health units that the NFB protocol, guidance document and food costing methods no longer reflected their communities’ purchasing realities” (personal communication with Amy Gartner, MOHLTC, 27 November 2017). This suggests that the MOHLTC either does not know or is unconcerned with the fact that there are no other tools available to assess food costs, and that it is a complex process to develop an instrument that accurately reflects nutrient requirements, health recommendations, and contemporary food purchasing patterns. Moreover, the MOHLTC gave no indication that it was aware that the National Nutritious Food Basket protocol would likely be updated by Health Canada once the new Canada’s Food Guide was made public. Instead, it gave a clear message that it was not—and would not be—interested in developing the necessary support and expertise within the Ministry for PHUs to carry out this valuable work. Our research adds to other evidence of a critical weakening of public health’s ability to be effective in its work (Guyon et al. 2017; Potvin 2014).

Discussion and Conclusion

Our findings offer valuable insights regarding the importance of NFB costing in the health equity advocacy work of PHUs in Ontario, and we have distilled these insights down to four lessons to inform public health policy and practice. First, there was unanimous agreement among interviewees that NFB research provides valuable, localized evidence of inadequate incomes for people living in poverty. The NFB research not only supports the health equity mandate of PHUs in Ontario, but for many PHUs, it is the only substantive health equity advocacy action in which

they engage. Without a mandate to carry out NFB costing, those PHUs that do not offer their staff a supportive environment for health equity advocacy will be even less likely to do so.

Second, the value of the NFB tool can be leveraged by ensuring an organizational environment within PHUs that respects and supports the usefulness of the NFB research for health equity advocacy. Other research shows that commitment and support from senior management in PHUs are essential to health equity advocacy work (Cohen and Marshall 2017). Raphael et al. (2015) argue that the willingness of medical officers of health to address social determinants of health in a broad, structural fashion is more important than financial resources, community support, and a progressive political climate in determining PHUs’ engagement in health equity advocacy.

Third, public health can support the wider community to engage with NFB research in a thoughtful way. PHUs are well positioned to play a leadership role in developing community coalitions for advocacy where they do not already exist, and supporting existing health equity advocacy initiatives. By working in coalition with community partners, public health can encourage the community mobilization and capacity building required to build broad public support for health equity (Johnson et al. 2015; Williams 2014).

Finally, the NFB provides strong, localized evidence about poverty as a determinant of food insecurity. The stark evidence base that the NFB costing provides empowers PHUs to endorse effective policy measures, such as a basic income guarantee, as a defensible strategy for advancing health equity in Ontario.

Our research provides compelling evidence of the usefulness of food basket costing exercises for advancing health equity in relation to adequate income. More widespread and effective use of food costing can help break down stereotypes of people living in poverty, mobilize communities, and build the political will necessary to reduce poverty, the root cause of food insecurity. Public health has the potential to provide consistent and capable expertise for this crucial health equity agenda, but progress towards that goal is unlikely without provincially mandated activities and support for the fulfillment of that mandate.

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