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Comparing Ideology and COVID-19 Preferences of Canadian Public Health Workers and the General Population

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ABSTRACT

Objectives

This study tests whether and how the Canadian public health workforce differed from the Canadian general population in their political attitudes, worldviews and policy preferences related to the COVID-19 pandemic.

Methods

Nearly identical surveys were fielded to the Canadian public health workforce in 2021 through leading public health associations and to a census-balanced sample of the general Canadian population in February and March 2021. through a consumer quota sample for a survey of the general population.

Results

The Canadian public health workforce demonstrates systematically more left-wing pro-egalitarian, anti-hierarchical, anti-individualist worldviews. Those in health promotion positions are slightly more to the left than those in non-health promotion positions. However, the public health sample did not uniformly favour stricter COVID-19 containment and prevention policies than the general population. When modelling COVID-19 prevention policies as a function of cultural worldviews and ideology, it appeared that these had a greater effect on policy preferences in the general population than in the public health sample.

Conclusion

The public health workforce is more left-wing than the general population and professionals in health promotion positions are more left-wing than others in public health. But the public health workforce did not uniformly prefer stricter COVID-19 prevention policies. Cultural worldviews and ideology were stronger predictors of policy preferences for the general population than for the public health sample respondents.

INTRODUCTION

We present results of the first survey of demographic characteristics and political attitudes of Canada's public health workforce. There are two objectives. The first is to improve public understanding of the demographic characteristics of Canada's public health workforce. The Chief Public Health Officer identified limited knowledge as an important problem in her 2021 annual report (2021). The second is to assess the degree to which public health professionals share ideology and political attitudes with the general population.

The field of public health has been entangled with politics and ideology from its inception. Early theories of the propagation of disease and illness were selected and discarded based on the type of social reform they implicated (Hamlin 1995). For example, efforts to expand water fluoridation and to reduce tobacco use generated concerns about reducing individual liberties (Beauchamp 1980; Gamson 1961; Carstairs and Elder 2008). While these initiatives have strong ethical foundations in that they seek to maximize welfare and distribute life chances equally, these are not the only ethical or value commitments people adhere to in society. Liberty and respect for established authority are also a widely shared value commitment in Canadian political culture (Ajzenstat 2014; Horowitz 1966). Krashinsky and Lews (2024) show that the greater adherence to laissez-faire attitudes in the United States may be implicated in the greater resistance to COVID-19 containment and mitigation measures. Public health must take into account value conflicts and politics to be successful (Fafard, Cassola, and de Leeuw 2022). At the same time, existing survey evidence of the political correlates of support for COVID-19 measures shows that while perceptions of the severity of COVID-19 was related to political ideology, an early elite consensus about the importance of COVID-19 containment measures lead to a corresponding consensus in the public (Merkley et al. 2020). However, systematic survey evidence is lacking about how views of public health professionals do or do not differ from the general population. This paper examines this question.

To develop our hypotheses, we relied on two theoretical perspectives used to study the intersection of politics, ideology, science and public health. First, we start with a theory of risks, developed by Douglas and Wildavsky (1983). This theory argues that rather than constituting objective threats to well-being, risks are constructed to reinforce preferred forms of social organization, or worldviews. Groups must make fundamental choices about the degree to which they will be organized on a hierarchical-egalitarian dimension and on an individualist-collectivist dimension. On the first dimension, individuals express preferences for the degree to which social life is regimented with clear role definitions. Hierarchs prefer clear role definitions and highly regimented group life; individuals prefer flatly organized group life, with minimal hierarchical distinctions. On the second dimension, individuals express preferences for groups with strong boundaries and low levels of individual autonomy, or weak boundaries and high levels of autonomy. This creates four quadrants of cultural worldviews: hierarchism, individualism, egalitarianism and fatalism.[1] This theoretical approach has been used extensively to study public opinion in public health areas such as water fluoridation (Perrella and Kiss 2015; Perrella, Kiss, and Shankardass 2023), the HPV vaccine (Kahan et al. 2010), childhood vaccination policy (Song, Silva, and Jenkins-Smith 2014) and drinking water quality (Koehler et al. 2018).

[1] Typically, fatalism is dropped from analysis in the interests of parsimony.

We also draw on previous studies of public health as a profession to test hypotheses about whether there are political divisions *within* public health. Professions and their associations are sites of profound internal conflict over goals, knowledge and power (Abbott 2014, 151–53). Tengland (2010) argues that public health has two competing visions: disease prevention and health promotion. Disease prevention had a narrow and medical conception of health as the absence of disease while the latter had a more holistic, positive conception of health that implied social and political reform for egalitarian ends.

What is at stake here is the degree to which Canadian public health workers share different cultural worldviews from the general population and the degree to which these shape their recommendations for action. Given the foregoing, we tested four primary hypotheses.

H1: The Canadian public health workforce demonstrates more egalitarian, less individualistic and less hierarchical worldviews than the general population.

H2: The Canadian public health workforce is divided in worldviews between those in health promotion positions and those in other public health positions.

H3: The public health workforce prefers stricter COVID-19 containment and prevention measures than the general population.

H4: Pro-egalitarian and pro-hierarchical worldviews are related to support for COVID-19 containment and prevention measures while pro-individualistic worldviews are related to opposition to COVID-19 containment and prevention measures in both the general population and the public health workforce.

METHODS

Sample Selection

It is not simple to define what the Canadian public health workforce is as it includes many professions, regulated and unregulated (The Joint Task Group on Public Health Human Resources 2005). Because there is no publicly available sampling frame from which anyone could contact public health professionals, we developed a sampling strategy with the Canadian Public Health Association such that leading public health associations in Canada would distribute invitations to participate.[2] Information on the participating organizations is contained in the supplemental material. A nearly identical survey was fielded to a census-balanced online commercial panel of Canadian respondents, using quota sampling to match the gender and regional distribution the most recent population estimates provided by Statistics Canada.[3]

Survey Instrument

The questionnaire was developed in consultation with and approved by the Canadian Public Health Association and is available as part of the supplementary material. Our key measures are left-right ideology, cultural worldviews, COVID-19 policy preferences and demographic variables. Cultural worldviews were measured with 10 7-point Likert items validated and used in other studies (Kiss, Lachapelle, and Montpetit 2020; Jones 2011). Left-right ideology was

[2] Excluded from analysis are 12 respondents of the final public health sample who were students, a category of membership with the CPHA.

[3] The surveys only differed in that public health respondents were presented questions about the focus of their position, managerial / supervisory status, employer and membership status in public health associations.

measured with a standard 10-point scale (Stephenson et al. 2022). COVID-19 policy preferences were measured in two ways: first, with 7-point Likert items ranging from strongly disagree to strongly agree, and second, with a scale the endpoints of which were two desirable but opposite outcomes.

Data Collection

The survey for the general population was fielded between February 16th – 23rd, 2021 while the public health survey was fielded from February 16th- March 19th, 2021. Both were fielded at the end of the second weave of the COVID-19 pandemic.

Data Quality

Distributing the survey posed some challenges. The survey was fielded in the middle of the COVID-19 pandemic, which meant that respondents were occupied with more important matters. Moreover, health workers were surveyed frequently surveyed on many subjects, potentially leading to survey fatigue (de Koning et al. 2021). Distributing the invitation to participate through the public health associations meant that it was not always clear how many participants received the invitation, and how many invitations were distributed, making proper calculations of a response rate impossible.

Before analysis, both samples were assessed for data quality by identifying respondent "straightlining" (where respondents indiscriminately select the same response to a battery of questions) and speeding (survey completion time 30% that of the median completion time). From this, 176 respondents were excluded because of straightlining, leaving 1820 respondents.

Because there are no other publicly available studies of the population of Canada's public health workforce (a gap which this study seeks to fill), it is nearly impossible to validate the representativeness of this portion of the study. However, the regional distribution of the sample's CPHA members (44% in Ontario) closely match that of the CPHA membership (39% in Ontario). Full details are in the supplementary material.

Our sample of the general population is older, richer, less francophone, more rural and more educated than Canada's population.[4] More respondents, 47.9%, reported voting Liberal in the 2019 federal election than the 33.1% in the actual election. Fewer respondents reported voting NDP than the actual vote result (11.66% versus 16%); the same for BQ voters (3.3% versus 7.6%). However, the sample more closely matches the Conservative vote (31.93% versus 34.3%), and Green voters (5.18% versus 6.6%). More than three-quarters of respondents (77%) indicated intentions to get the COVID-19 vaccine, which is close to what was reported in two other surveys conducted at around the same time (81% and 82%).[5]

[4] Analysts often post-stratify samples in situations with these kinds of sub-group deviations from representative online panels. However, this is not without disadvantages. Moreover, some of these demographic variables are linked in opposite ways to Canadian political behaviour. For example, while rural, older and richer Canadians are more socially conservative, educated Canadians are not (Segaert 2008; Wasko and O'Neill 2007; McGrane, Berdahl, and Bell 2016; Armstrong, Lucas, and Taylor 2022; Kiss, Graefe, and Polacko 2023). As a basic test, we replicated Figure 1 and Figure 3 and found no meaningful differences between those and what are reported here. Consequently, we use the unweighted general population samples.

[5] Exact tables for these comparisons are in supplementary material.

RESULTS

First, we use Census data to compare our sample of the Canadian public health workforce with census data of general Canada's workforce. Results are in Table 1.

Table 1: Demographic characteristics of public health sample with 2021 census data for Canadians with employment income

Our sample of the public health workforce is more female, more educated, and wealthier than the Canadian workforce. Because, these demographics are frequently associated with distinct political attitudes, controlling for these demographic variables is essential when comparing public health attitudes with those of the general population. We can also show the distribution of public health respondents by public health field in Table 2. Respondents could select from four options: Health promotion, health protection, epidemiology, and emergency preparedness and response.

Table 2: Distribution of public health respondents and self-reported field

To test H1, that public health respondents are more left-wing, more egalitarian and hierarchical, but less individualistic than the general population, we compare the average scores on 11 items measuring respondents' self-reported ideology and cultural worldviews. Figure 1 shows the average score on each item for the general population and the public health sample, where each item's responses have been scaled from 0 to 1 such that a 1 represents a right-wing position (hierarchical or individualistic) and 0 a left-wing position (egalitarian or communitarian). Differences greater than the confidence intervals are evident on every item. The public health workforce is distinctly more left-wing, egalitarian and communitarian than the general population. In separate regressions reported in the supplementary material, these differences remained after introducing demographic controls for age, gender, income, education, and rural-urban residency. This suggests H1 is confirmed.

Figure 1: *This figure shows the average score (with 95% CI) on the self-reported ideology and worldview measures for the general population and the public health sample. Scores have been re-scaled such that 1 is a conservative (pro-hierarchical, anti-egalitarian and anti-individualist)*

Next we test H2, that there are differences *within* Canada's public health workforce. As emphasized in the introduction, we expect those in the field of health promotion to have more left-wing positions because of health promotion's tendency to identify the social determinants of health emphasize social reforms as solutions (Rootman et al. 2017). We tested for differences in ideology and worldviews between those who selected health promotion as their field and all others. We used the same measures as to test H1. Results are in Figure 2. Here, differences are still evident, although they are smaller. There are statistically significant differences in self-reported left-right ideology, respect for authority and the importance of strict punishments. On eight of the nine other items, there are smaller differences, within standard 95% confidence intervals where health promotion respondents hold more left-wing views than others. The systematic nature of these differences suggest they are real but small.

Figure 2: *Ideology and worldviews by public health field, health promotion versus other (health protection, epidemiology and emergency preparedness). Item scores have been scaled 0 (liberal, egalitarian, anti-individualist, anti-hierarchical) to 1 (conservative, anti-egalitarian, hierarchical and individualist)*

While there are discernible differences in worldviews and ideology between the general population and the public health workforce and within the public health workforce, it remains to be seen whether there are differences in specific policy preferences. In H3, we hypothesized that the public health workforce would support stricter COVID-19 prevention and mitigation policies. To test this, we examine support for a series of policies that emerged in the pandemic, namely, mandatory vaccinations, fines for people not wearing masks and the forced closure of bars and restaurants. Given the findings above that there are divisions within the public health workforce, we report these results differentiating respondents in health promotion, other public health positions and the general population. Figure 3 shows the average support by each group for the three policies, scaled from 0 to 1, such that 0 is strong disagreement with the policy and 1 is strong agreement. There was a striking alignment in policy preferences between the public health and general population samples. The only difference between the two groups was counter-intuitive and contrary to H3. Specifically, the general population was *more* likely to support mandatory vaccines than was the public health workforce.

Figure 3: *Support for COVID-19 intervention policies by sample, public health workforce versus general population. Responses scaled so that 1 indicates strong agreement with a stringent, COVID-19 prevention and containment policy, 0 indicates strong disagreement*

In a second set of questions, designed to mirror the trade-offs inherent in public policy, greater divisions emerge between public health respondents and the general population. In these questions, respondents were asked to choose between two desirable outcomes: the mitigation and containment of COVID-19 or, in order, stopping economic decline, providing a reprieve from social isolation, keeping schools open or providing a reprieve from isolation for seniors specifically. Results in Figure 4report the average support for the competing policies by sample. The general population preferred stopping economic decline to containing COVID-19 more than public health respondents, but public health respondents preferred keeping schools open to containing COVID-19 to the general population.[6] Overall, these two sets of results suggest that H3 is largely, not exclusively, disconfirmed; public health respondents did not uniformly prefer stricter COVID-19 policies than the general population. It was only when containing COVID-19 was directly set against the choice of stopping economic decline that this was the case.

Figure 4: *Support for policy trade-offs by public health group. Responses scaled from 0 to 1 such that 0 means the respondent prefers the outcomes on the y-axis and 1 means the respondent prefers preventing and containing COVID-19*

Next, we integrate these findings, modelling respondent support for these COVID-19 prevention and mitigation policies as a function of worldviews. To do so, we generated scores for egalitarianism, individualism and hierarchism from the questions designed to measure worldviews.[7] Table 3 shows the coefficients and standard errors for the relationship between

[6] While confidence intervals for health promotion respondents overlap with those of the general population, when the public health respondents are pooled, differences between them and the general population respondents are clear.
[7] We derived these scores through a principal component analysis of the 10 items used to measure respondent cultural worldviews. This suggested three theoretically coherent components. Scores from this three-component model, centered and standardized are used as covariates in subsequent OLS regressions. Results of the principal component analysis are reported in the online appendix.

cultural worldviews and each of the three policy items: mandatory vaccines, fines for masking and closing bars and restaurants. Because the dependent variables in these models have been scaled from 0 to 1, these coefficients can be interpreted as a percentage shift in support for COVID-19 prevention and containment per standard deviation change in worldviews. The underlying models contain controls for demographic variables and full tables are available in supplemental material online.

Table 3: This shows OLS coefficients for relationships between worldviews and three COVID-19 containment and prevention public health policies. Coefficients denote how much a 1-standard deviation change in worldviews are related to an increase in support for each policy on a scale from 0 (strongly oppose) to 1 (strongly support). The full models contain controls for gender, education, income, age and rural/urban status and are reported online in supplemental material

We find clear evidence that worldviews are related to COVID-19 policy preferences for the general population, but that relationship appears somewhat weaker for public health respondents. For the general population, both egalitarianism *and* hierarchism are significantly and positively related to support for more stringent COVID-19 prevention and mitigation measures. Individualism, however, is clearly negatively related to support for the same measures. In the public health sample, egalitarianism is *not* related to support for more stringent COVID-19 prevention and mitigation measures but respondents' hierarchism is related to support for mandatory vaccines and for closing bars and restaurants while respondents' individualism is related to opposition to mandatory vaccines and fines for non-masking.

When we model respondent support for trade-offs, we also find evidence that worldviews shape preferences in both the general population and the public health sample. **Error! Reference source not found.**Table 4 shows results for the relationships between cultural worldviews and the trade-offs associated with managing COVID-19. Again, egalitarianism is clearly and positively related to a preference to stopping the spread of COVID-19 at the expense of every other objective. Hierarchism is related, albeit weakly, to a preference for preventing the spread of COVID-19 at the expense of providing a relief from isolation for the public in general or seniors specifically. Lastly, individualism is only negatively related to a preference to stopping the spread of COVID-19 at the expense of stopping economic decline and providing reprieve for seniors. For public health respondents, only egalitarianism is related to their preference to stop COVID-19 compared to stopping economic decline, providing a reprieve from isolation and keeping schools open. Overall, this suggests mixed support for H4; worldviews are clearly predictive of respondent support for COVID-19 containment and prevention policies for the general population but less so for public health respondents.

Table 4: This shows OLS coefficients for relationships between worldviews and preferences for COVID-19 containment and prevention versus other desirable outcomes. Coefficients denote how much a 1-standard deviation change in worldviews are related to a change in support for COVID-19 containment on a scale of 0 to 1. The full models contain controls for gender, education, income, age and rural/urban status and are reported online in supplemental material

DISCUSSION

Overall, these data confirm Hypotheses 1 and 2. Public health professionals in our sample reported notably different cultural worldviews and ideologies compared to the general population. Moreover, there was also a distinction *within* the public health community by field. Those in health promotion were notably to the left, more egalitarian, less hierarchical and more individualistic than those in other public health positions. This fits with previous literature on public health as a profession that has identified health promotion, in particular, of closely linking the improvement of health outcomes with policy reforms. However, our third hypothesis, that public health workers would prefer more stringent COVID-19 policies, was only partially confirmed. On the one hand, when presented in the form of Likert items where respondents were invited to agree or disagree with a series of items, there was widespread agreement between the public health and the general population sample. If anything, the public demanded more stringent policies in the form of mandatory vaccines. This result is somewhat surprising given the public opposition that existed to many COVID-19 policies implemented by or recommended by public health officials. That said, there were also moments in Canadian debate about the pandemic where the public, or major elements of the public, demanded stricter policies than were being recommended by public health agencies. For example, in 2020, there were demands by many citizens for stricter recommendations for masking which Canada's Chief Medical Officer of Health avoided. Similarly, there were demands by many to close public schools as they were seen to be vectors of transmission, which many public health officials rejected. While speculative, one plausible explanation is that public health professionals are aware of the ways in which stringent public health measures have historically been enacted to reinforce and entrench hierarchies of various kinds. For example, Eyford (2006) has documented how a smallpox epidemic in Manitoba in1876 was used by the federal government as an excuse to forcibly move local indigenous populations onto reserves.

Clearer differences emerged only the survey presented a sharper choice, requiring respondents to choose between two desirable outcomes. Here, public health professional did choose stricter policies than the public when the choice was presented as being between stopping economic decline and preventing the spread of COVID-19. However, when the choice was between keeping schools open and preventing COVID-19, our sample of the general population was stricter than public health professionals. Overall, our data only partially support common libertarian claims that public health workers demonstrated uniformly more stringent measures than members of the public.

It is also important to reiterate some limitations to inferences from the sample of public health workers. First, the sample size was rather small, which makes it hard to detect differences. This may have been a product of the fact that public health workers in Canada were under extreme pressure managing the pandemic. It may also have been a product of survey fatigue as many scholars were surveying health professionals during the pandemic (de Koning et al. 2021). Moreover, membership is these associations is not mandatory and some groups may be underrepresented in our sample of the public health workforce. However, while fielding the survey during the intensity of a pandemic may have limited the sample size, it may have increased the external validity as it surveyed public health respondents and the general population during a crisis when views on public health were most salient.

CONCLUSION

To our knowledge, this is the first attempt to survey the worldviews, political ideology and demographics of the public health workforce in Canada. It demonstrated that the public health workforce holds distinctly left-wing, pro-egalitarian, anti-hierarchical and anti-individualist

sentiments. Moreover, we also observed a distinction asserted in the scholarly literature on the discipline of public health, namely, those in the health promotion fields were significantly more left-wing, pro-egalitarian, anti-hierarchical and anti-individualist than other public health workers. At the same time, these data did not demonstrate that public health workers had a clear preference for stricter COVID-19 prevention and mitigation policies compared to the general population; results were much more mixed. Moreover, relationships between worldviews and preferences were weaker amongst the public health sample than amongst the general population.

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Tables and Figures

Variable	Label	Value	Sample	Labour Force
Age	Age Category (2), R Age	25-54	85	77
Age	Age Category (2), R Age	55-64	15	23
High Income	Dichotomous variable, R household > $100,000	Over $100,000	67	49
High Income	Dichotomous variable, R household > $100,000	Under $100,000	33	51
Francophone	Dichotomous variable, R is francophone	Francophone	6	22
Francophone	Dichotomous variable, R is francophone	Not Francophone	94	78
Rural	Dichotomous variable, R lives in a rural neighborhood	Not Rural	61	81
Rural	Dichotomous variable, R lives in a rural neighborhood	Rural	39	19
Degree	Dichotomous variable, R has university degree	Degree	96	31
Degree	Dichotomous variable, R has university degree	No Degree	4	69
Female	Dichotomous variable, R is female	Female	75	48
Female	Dichotomous variable, R is female	Not Female	25	52
Province	Province of Residence	Alberta	12	12
Province	Province of Residence	British Columbia	15	14
Province	Province of Residence	Manitoba	17	4
Province	Province of Residence	New Brunswick	1	2
Province	Province of Residence	Newfoundland and Labrador	1	1
Province	Province of Residence	Nova Scotia	3	3
Province	Province of Residence	Ontario	39	39
Province	Province of Residence	Prince Edward Island	2	0
Province	Province of Residence	Quebec	5	23
Province	Province of Residence	Saskatchewan	3	3

Table 1: Demographic characteristics of public health sample with 2021 census data for Canadians with employment income

Public Health Field	n
Health protection	97
Health promotion	54
Epidemiology	20
Emergency Preparedness and response	7

Table 2: Distribution of public health respondents and self-reported field

	Vaccines		Close Bars and Restaurants		Fines for Non-Masking	
	General Population	**Public Health**	**General Population**	**Public Health**	**General Population**	**Public Health**
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**
Egalitarianism	0.05***	-0.01	0.07***	-0.01	0.05***	0.01
	(0.01)	(0.03)	(0.01)	(0.03)	(0.01)	(0.03)
Hierarchism	0.07***	0.10***	0.07***	0.05*	0.05***	-0.01
	(0.01)	(0.03)	(0.01)	(0.02)	(0.01)	(0.02)
Individualism	-0.04***	-0.06*	-0.02**	0.01	-0.06***	-0.07**
	(0.01)	(0.03)	(0.01)	(0.02)	(0.01)	(0.02)
Num.Obs.	1815	177	1815	177	1815	177
R2	0.127	0.157	0.138	0.072	0.116	0.137
R2 Adj.	0.123	0.117	0.134	0.028	0.112	0.096

+ p < 0.1, * p < 0.05, ** p < 0.01, *** p < 0.001

Table 3: This shows OLS coefficients for relationships between worldviews and three COVID-19 containment and prevention public health policies. Coefficients denote how much a 1-standard deviation change in worldviews are related to an increase in support for each policy on a scale from 0 (strongly oppose) to 1 (strongly support). The full models contain controls for gender, education, income, age and rural/urban status and are reported online in supplemental material

	Stop Economic Decline		Reprieve From Isolation		Keep Schools Open		Reprieve For Seniors	
	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Egalitarianism	0.10***	0.05*	0.08***	0.05*	0.08***	0.07*	0.07***	0.03
	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.03)	(0.01)	(0.02)
Hierarchism	0.02**	-0.01	0.04***	0.01	0.03***	0.02	0.03***	0.01
	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.02)
Individualism	-0.02**	-0.02	0.00	0.01	0.00	0.01	0.01*	0.01
	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.02)	(0.01)	(0.02)
Num.Obs.	1815	177	1815	177	1815	177	1815	177
R2	0.168	0.117	0.131	0.058	0.096	0.106	0.090	0.043
R2 Adj.	0.165	0.075	0.127	0.013	0.092	0.063	0.086	-0.003

* $p < 0.05$, ** $p < 0.01$, *** $p < 0.001$

Table 4: This shows OLS coefficients for relationships between worldviews and preferences for COVID-19 containment and prevention versus other desirable outcomes. Coefficients denote how much a 1-standard deviation change in worldviews are related to a change in support for COVID-19 containment on a scale of 0 to 1. The full models contain controls for gender, education, income, age and rural/urban status and are reported online in supplemental material

So What….

1. **What does this study add to existing knowledge?**
   Canada's public health workforce holds distinctly left-wing political attitudes from the general population, even after controlling for the demographic differences between the general population and the public health workforce. While there was some alignment on public policies in containing COVID-19, there was some divergence as well. This was only partially explained by the distinct attitudes.
2. **What are the key implications for public health interventions, practice or policy?**
   Public health policies rest on a particular ranking of values which are evidently embedded in public health professions. These may not be shared by the general population and can engender conflict, particularly in non-crisis policy domains. Public health professionals must take competing value systems seriously in making recommendations.

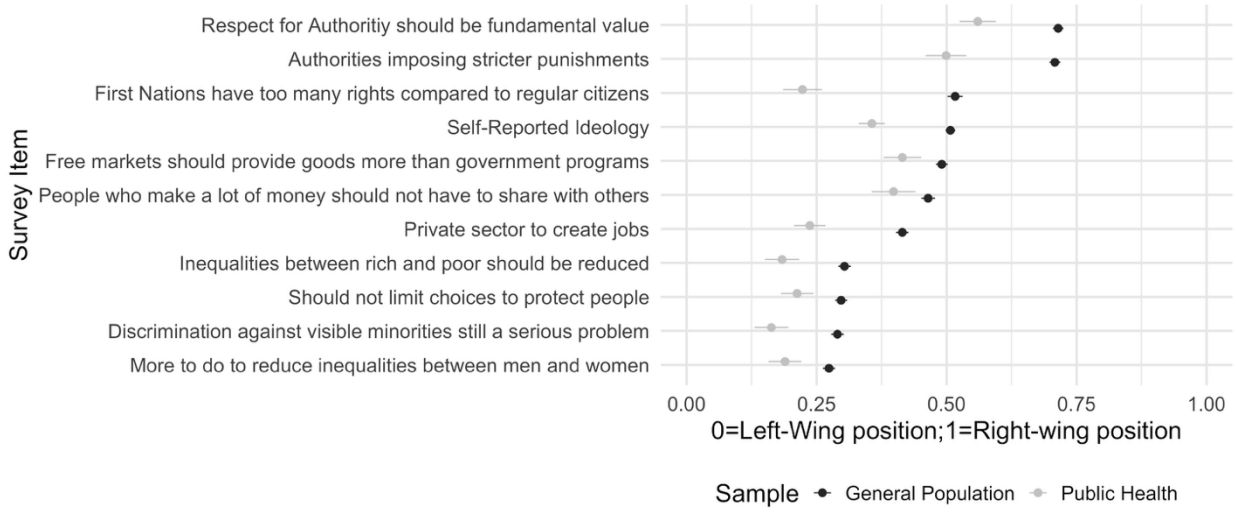

Figure 1: This figure shows the average score (with 95% CI) on the self-reported ideology and worldview measures for the general population and the public health sample. Scores have been re-scaled such that 1 is a conservative (pro-hierarchical, anti-egalitarian and anti-individualist)

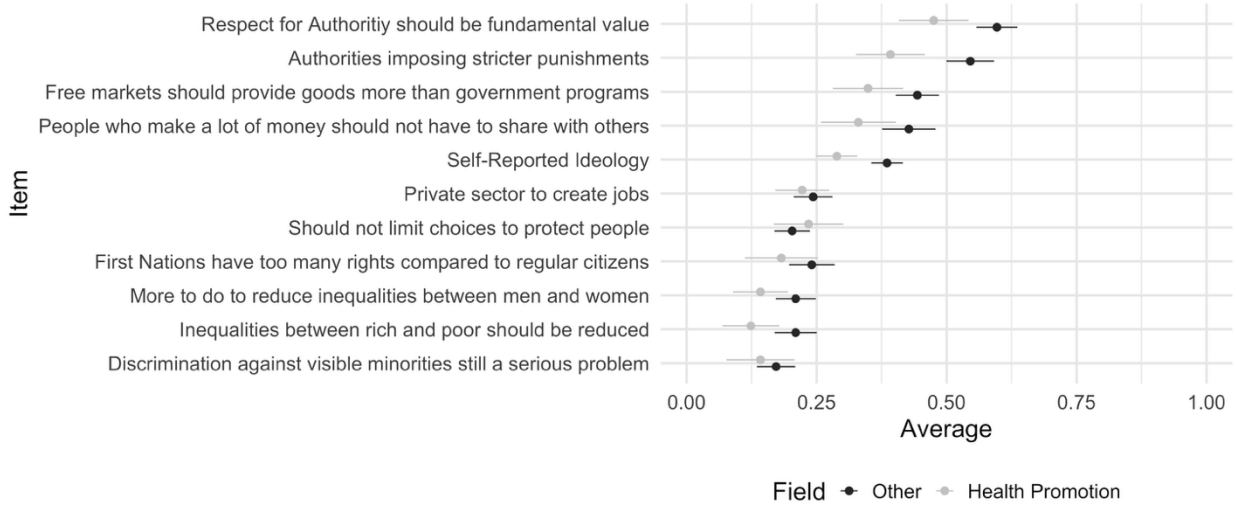

Figure 2: Ideology and worldviews by public health field, health promotion versus other (health protection, epidemiology and emergency preparedness). Item scores have been scaled 0 (liberal, egalitarian, anti-individualist, anti-hierarchical) to 1 (conservative, anti-egalitarian,

hierarchical and individualist).

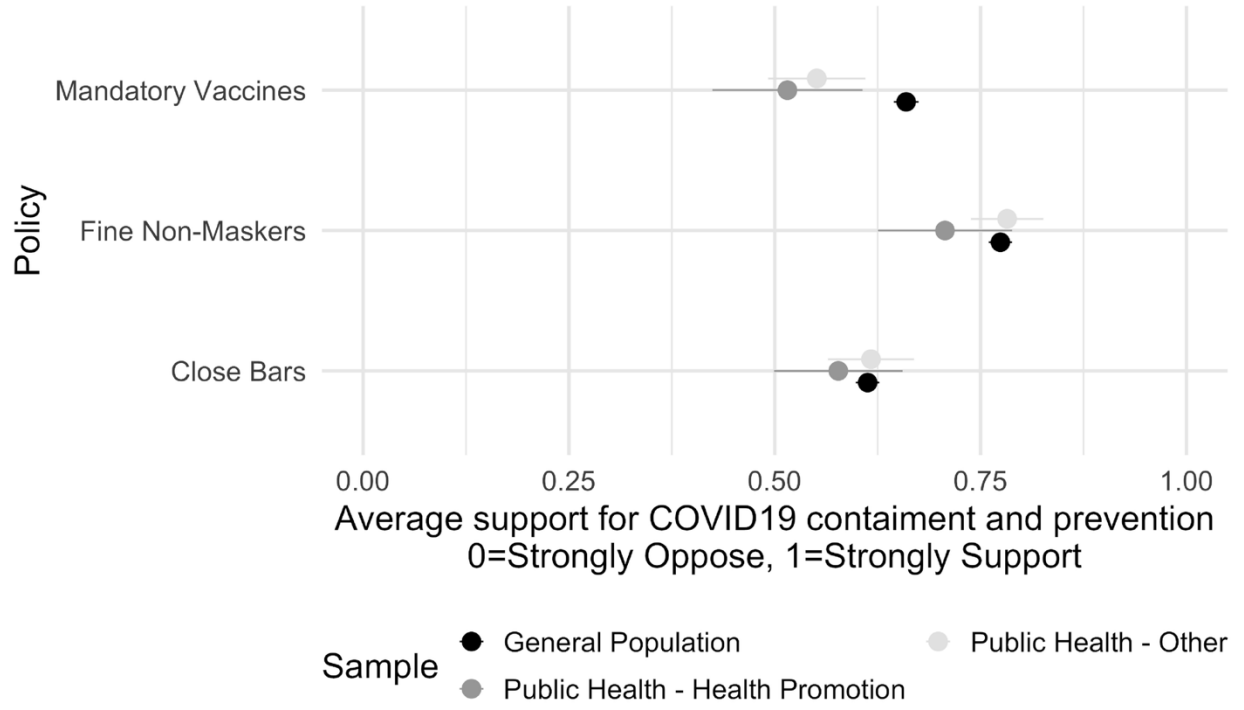

Figure 3: Support for COVID-19 intervention policies by sample, public health workforce versus general population. Responses scaled so that 1 indicates strong agreement with a stringent, COVID-19 prevention and containment policy, 0 indicates strong disagreement.

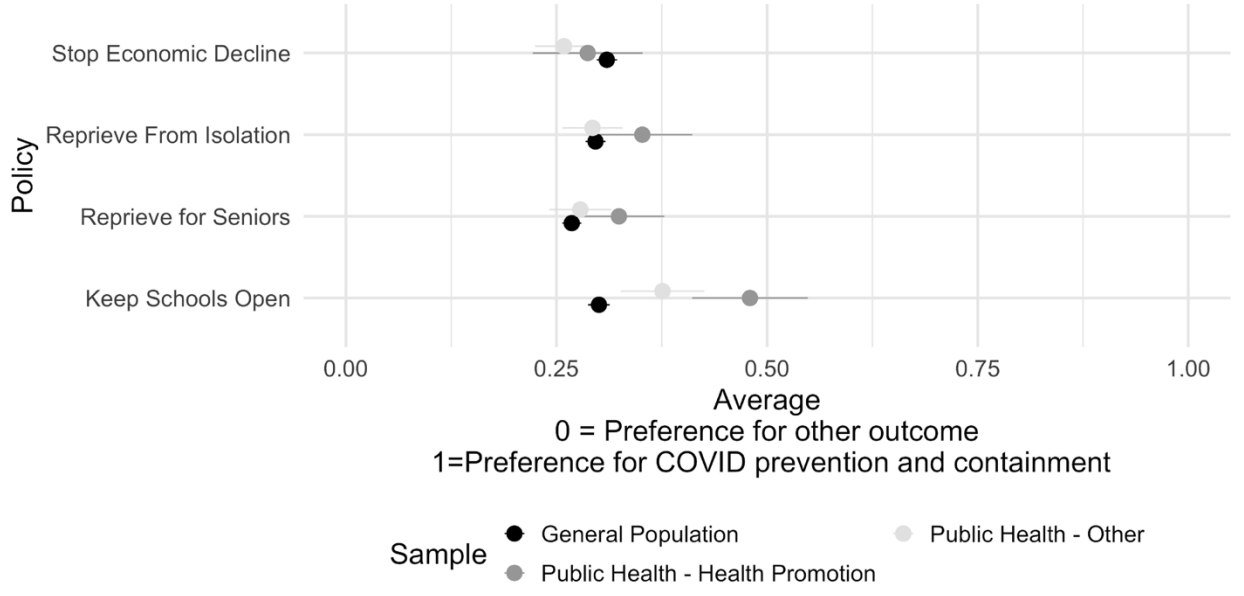

Figure 4: Support for policy trade-offs by public health group. Responses scaled from 0 to 1 such that 0 means the respondent prefers the outcomes on the y-axis and 1 means the respondent prefers preventing and containing COVID-19.

Electronic Supplemental Material

Association	Status
Public Health Physicians of Canada	Agreed to participate
CPHA	Agreed to participate
Ontario Public Health Association	Agreed to participate
Health Promotion Canada	Agreed to participate
ASPQ	Agreed to participate
Manitoba Public Health Association	Agreed to participate
Public Health Association of NB/PEI	Agreed to participate
Community Health Nurses of Canada	Sent Distribution Email, No response
Canadian Institute of Public Health Inspectors	Sent Distribution Email, No response
Public Health Association of BC	Sent Distribution Email, No response
Public Health Association of NS	Sent Distribution Email, No response
Alberta Public Health Association	Sent Distribution Email, No response
Newfoundland Public Health Association	Sent Distribution Email, No response
Public Health Association SK	Sent Distribution Email, No response

Table A1 This table shows the list of public health associations contacted to participate in the survey and their response

Organization	n
Provincial	84
CPHA	61
CIPHI	45
PHPC	21
HPC	13
Other Association	11
ASPQ	4
Total —	239

Table A2 This table shows the distribution of public health respondents' organizational affiliations. Respondents could choose more than one option so the total is greater than the number of respondents in the dataset

Region	n	CPHA n	Sample Percent	CPHA Percent
Sample				
Ontario	278	24	44	39
West	246	29	39	48
Atlantic	53	3	8	5
Quebec	52	4	8	7
North	9	1	1	2

Table A3 Regional distribution of CPHA membership and self-reported CPHA members in surveyed sample

Party	Sample	Lower	Upper	Election
Liberal	47.93	45.34	50.62	33.10
Conservative	31.93	29.34	34.63	34.30
NDP	11.66	9.07	14.35	16.00
Green	5.18	2.59	7.88	6.60
BQ	3.30	0.71	6.00	7.60

Table A4 Reported 2019 vote in the general population sample compared with actual vote results

Variable	Label	Value	Sample	Census
High Income	Dichotomous variable, R household > $100,000	Over $100,000	27	8
High Income	Dichotomous variable, R household > $100,000	Under $100,000	73	92
Francophone	Dichotomous variable, R is francophone	Francophone	10	21
Francophone	Dichotomous variable, R is francophone	Not Francophone	90	79
Rural neighborhood	Dichotomous variable, R lives in a rural	Not Rural	67	81
Rural neighborhood	Dichotomous variable, R lives in a rural	Rural	33	19
Degree degree	Dichotomous variable, R has university	Degree	42	19
Degree degree	Dichotomous variable, R has university	No Degree	58	81
Female	Dichotomous variable, R is female	Female	51	51
Female	Dichotomous variable, R is female	Not Female	49	49
Province	Province of Residence	Alberta	11	12
Province	Province of Residence	British Columbia	12	13
Province	Province of Residence	Manitoba	4	4
Province	Province of Residence	New Brunswick	2	2
Newfoundland and				

Province	Province of Residence		2	1
Labrador				
Variable	Label	Value	Sample	Census
Province	Province of Residence	Nova Scotia	3	3
Province	Province of Residence	Ontario	39	38
Province	Province of Residence	Prince Edward Island	0	0
Province	Province of Residence	Quebec	24	23
Province	Province of Residence	Saskatchewan	3	3
Age	NA	Over 65	28	17
Age	NA	Under 65	72	83

Table A5 Comparison of the study's sample of the general population with the Canadian 2021 census of population, on selected demographic characteristics

Factor analysis results

	Factor_1	Factor_2	Factor_3	Communality	Uniqueness	Complexity
	Egalitarianism	Hierarchism	Individualism			
Discrimination against visible minorities still a serious problem	0.79	0.13	−0.09	0.70	0.30	1.08
More to do to reduce inequalities between men and women	0.76	0.17	−0.14	0.70	0.30	1.17
First Nations have too many rights compared to regular citizens	−0.68	0.42	−0.15	0.62	0.38	1.77
Private sector to create jobs	−0.61	0.18	−0.20	0.37	0.63	1.42
Inequalities between rich and poor should be reduced	0.52	0.04	−0.48	0.67	0.33	2.00
Authorities imposing stricter punishments	−0.03	0.85	0.07	0.73	0.27	1.02
Respect for Authority should be fundamental value	0.07	0.84	0.07	0.70	0.30	1.03
Should not limit choices to protect people	−0.34	−0.34	0.26	0.36	0.64	2.85
People who make a lot of money should not have to share with others	0.02	0.14	0.84	0.70	0.30	1.06
Free markets should provide goods more than government programs	−0.03	−0.01	0.73	0.56	0.44	1.00

Table A6 Principal Component Analysis of 10 Likert items measuring cultural worldviews. Items were scaled from strongly disagree to strongly agree on a 7-point scale. Scores derived from this model were used in subsequent OLS regressions

Eigenvalues, Variance Explained, and Factor Correlations for Rotated Factor Solution

Property	Factor_1	Factor_2	Factor_3
SS loadings	2.53	1.82	1.75
Proportion Var	0.25	0.18	0.17
Cumulative Var	0.25	0.43	0.61
Proportion Explained	0.41	0.30	0.29
Cumulative Proportion	0.41	0.71	1.00
Factor_1	1.00	−0.03	−0.33
Factor_2	−0.03	1.00	−0.07
Factor_3	−0.33	−0.07	1.00

Table A7 Variance accounted for by the principal component model in Table A6

	Ideology	Self-Reported Inequalities between rich and poor should be reduced	Discrimination against visible minorities still a serious problem	More to do to reduce inequalities between men and women	Authorities should provide goods more than government programs	People who make a lot of money should not have to share with others	Should not limit choices to protect people	Private sector to create jobs	Authorities imposing stricter punishments	Respect for Authority should be fundamental value	First Nations have too many rights compared to regular citizens
Sample (Public Health)	-0.15**	-0.14***	-0.12***	-0.08***	-0.07***	-0.06*	-0.06**	-0.16***	-0.17***	-0.13***	-0.27***
	(0.02)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)	(0.02)	(0.02)	(0.02)	(0.02)	(0.03)
Degree											
Status (Degree)	-0.02*	0.02	-0.01	0.00	0.00	-0.05***	-0.06***	-0.03**	-0.05***	-0.03**	-0.06***
	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
Income (Over $100,000)	0.03*	0.07***	0.04**	0.03*	0.06***	0.06***	-0.02	-0.01	0.01	0.04**	0.05**
	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
Gender (Female)	-0.02**	-0.04***	-0.06***	-0.09***	-0.04***	0.01	-0.01	-0.04**	0.01	0.00	-0.05**
	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
Age (Over 45)	-0.01	0.03*	0.01	-0.01	0.07***	0.03	-0.05***	-0.02	0.07***	0.07***	0.01
	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.02)
Rural Resident	0.01	0.02	0.02	0.03*	0.04***	0.04**	0.01	0.02	0.00	0.01	0.03
	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)	(0.01)
Num.Obs.	1992	1992	1992	1992	1992	1992	1992	1992	1992	1992	1992
R2	0.052	0.047	0.039	0.047	0.053	0.024	0.031	0.046	0.086	0.069	0.085
R2 Adj.	0.050	0.044	0.036	0.044	0.050	0.021	0.028	0.044	0.083	0.066	0.083

* p < 0.05, ** p < 0.01, *** p < 0.001

Table A8 Regressions of ideology and cultural worldviews as a function of sample membership and demographic controls. These show that differences observed in Figure 1 are not attributable to demographic differences presented here between public health sample and general population sample respondents

	Mandatory Vaccines						Fines For Non-Masking						Close Bars and Restaurants					
	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health	General Population	Public Health
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)	(17)	(18)
(Intercept)	0.60***	0.88***	0.66***	0.62***	0.61***	1.00***	0.71***	0.96***	0.77***	0.81***	0.73***	1.01***	0.63***	0.86***	0.61***	0.57***	0.64***	0.84***
	(0.02)	(0.14)	(0.01)	(0.04)	(0.02)	(0.14)	(0.02)	(0.12)	(0.01)	(0.03)	(0.02)	(0.12)	(0.02)	(0.12)	(0.01)	(0.03)	(0.02)	(0.12)
Education (Degree)	0.03*	-0.39**			0.04*	-0.44**	0.04*	-0.15			0.04**	-0.15	0.02	-0.10			0.03+	-0.13
	(0.02)	(0.14)			(0.02)	(0.13)	(0.02)	(0.11)			(0.01)	(0.11)	(0.02)	(0.12)			(0.02)	(0.12)
Income (> $100,000)	0.02	-0.02			0.03	-0.02	0.01	-0.08+			0.01	-0.07+	-0.05**	0.00			-0.03+	0.00
	(0.02)	(0.05)			(0.02)	(0.05)	(0.02)	(0.04)			(0.02)	(0.04)	(0.02)	(0.05)			(0.02)	(0.05)
Gender (Female)	-0.05**	0.04			-0.07***	0.03	0.00	-0.01			-0.03*	0.00	-0.01	-0.12*			-0.03*	-0.12*
	(0.02)	(0.06)			(0.01)	(0.06)	(0.01)	(0.05)			(0.01)	(0.05)	(0.02)	(0.05)			(0.01)	(0.05)
Age (65+)	0.11***	-0.03			0.09***	-0.04	0.08***	-0.01			0.05***	-0.03	0.00	-0.11*			0.00	-0.09*
	(0.02)	(0.05)			(0.02)	(0.05)	(0.02)	(0.04)			(0.02)	(0.04)	(0.02)	(0.05)			(0.02)	(0.05)
Residence (Rural)	-0.05**	0.09+			-0.04**	0.09+	-0.02	0.02			-0.01	0.01	-0.04*	-0.06			-0.03+	-0.04
	(0.02)	(0.05)			(0.02)	(0.05)	(0.02)	(0.04)			(0.01)	(0.04)	(0.02)	(0.05)			(0.02)	(0.04)
Egalitarianism			0.04***	-0.03	0.05***	-0.01			0.07***	-0.02	0.07***	-0.01			0.04***	0.00	0.05***	0.01
			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.03)	(0.01)	(0.03)
Hierarchism			0.07***	0.09***	0.07***	0.10***			0.07***	0.04*	0.07***	0.05*			0.04***	-0.02	0.05***	-0.01
			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)
Individualism			-0.03***	-0.05+	-0.04***	-0.06*			-0.02*	0.02	-0.02**	0.01			-0.07***	-0.08**	-0.06***	-0.07**
			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)
Num.Obs.	1815	177	1820	178	1815	177	1815	177	1820	178	1815	177	1815	177	1820	178	1815	177
R2	0.039	0.070	0.087	0.080	0.127	0.157	0.017	0.032	0.122	0.042	0.138	0.072	0.008	0.068	0.109	0.080	0.116	0.137
R2 Adj.	0.036	0.042	0.086	0.064	0.123	0.117	0.014	0.004	0.121	0.025	0.134	0.028	0.005	0.041	0.108	0.064	0.112	0.096

+ p < 0.1, * p < 0.05, ** p < 0.01, *** p < 0.001

Table A9 OLS regression of COVID-19 containment and prevention policy preferences on cultural worldviews and demographic variables. Categorical variables are all dichotomous with reference category in parentheses. Cultural worldview items are centered and standardized such that each has a mean of 0 and a standard deviation of 1

Stop Economic Decline | Reprieve From Isolation | Keep Schools Open | Reprieve For Seniors

	General Health (1)	General Health (2)	General Health (3)	General Health (4)	General Health (5)	General Health (6)	General Health (7)	General Health (8)	General Health (9)	General Health (10)	General Health (11)	General Health (12)	General Health (13)	General Health (14)	Public on (15)	Public on (16)	Public on (17)	Public on (18)	Public on (19)	Public on (20)	Public on (21)	Public on (22)	Public on (23)	Public on (24)
(Intercept)	0.62***	0.92**	0.70***	0.68**	0.65***	0.91**	0.64***	0.82**	0.71***	0.67**	0.67***	0.83**	0.66***	0.93**	0.70***	0.57**	0.69***	0.95**	0.71***	0.81**	0.73***	0.69**	0.73***	0.82**
	(0.02)	(0.09)	(0.01)	(0.02)	(0.02)	(0.09)	(0.02)	(0.09)	(0.01)	(0.02)	(0.02)	(0.09)	(0.02)	(0.12)	(0.01)	(0.03)	(0.02)	(0.12)	(0.02)	(0.09)	(0.01)	(0.02)	(0.02)	(0.09)
Education (Degree)	0.01	-0.10			0.00	-0.14	0.01	-0.08			0.00	-0.11	0.00	-0.21			0.00	-0.26*	0.01	-0.02			0.01	-0.04
	(0.01)	(0.09)			(0.01)	(0.08)	(0.01)	(0.09)			(0.01)	(0.09)	(0.01)	(0.11)			(0.01)	(0.11)	(0.01)	(0.09)			(0.01)	(0.09)
Income (> $100,000)	-0.02	-0.05			-0.01	-0.05	-0.01	0.00			-0.01	0.00	-0.01	-0.09*			-0.01	-0.09*	-0.01	-0.04			-0.01	-0.04
	(0.01)	(0.03)			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.03)	(0.02)	(0.04)			(0.02)	(0.04)	(0.01)	(0.03)			(0.01)	(0.03)
Gender (Female)	0.02	-0.04			-0.01	-0.05	0.02	-0.06			-0.01	-0.07	0.03*	-0.05			0.01	-0.06	-0.01	-0.05			-0.03*	-0.06
	(0.01)	(0.04)			(0.01)	(0.04)	(0.01)	(0.04)			(0.01)	(0.04)	(0.01)	(0.05)			(0.01)	(0.05)	(0.01)	(0.04)			(0.01)	(0.04)
Age (65+)	0.07***	-0.05			0.06***	-0.03	0.07***	0.00			0.06***	0.01	0.04**	0.00			0.03	0.01	0.05***	-0.04			0.03*	-0.04
	(0.01)	(0.03)			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.03)	(0.02)	(0.04)			(0.01)	(0.04)	(0.01)	(0.03)			(0.01)	(0.03)
Residence (Rural)	0.00	-0.02			0.01	-0.01	0.00	-0.01			0.00	-0.01	-0.03	-0.08*			-0.02	-0.08	-0.02*	-0.01			-0.02	0.00
	(0.01)	(0.03)			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.03)	(0.01)	(0.04)			(0.01)	(0.04)	(0.01)	(0.03)			(0.01)	(0.03)
Egalitarianism			0.10***	0.05*	0.10***	0.05*			0.08***	0.04	0.08***	0.05*			0.08***	0.05	0.08***	0.07*			0.07***	0.03	0.07***	0.03
			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.03)	(0.01)	(0.03)			(0.01)	(0.02)	(0.01)	(0.02)
Hierarchism			0.02***	-0.01	0.02***	-0.01			0.04***	0.01	0.04***	0.01			0.03***	0.02	0.03***	0.02			0.03***	0.01	0.03***	0.01
			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)
Individualism			-0.01*	-0.02	0.02***	-0.02			0.00	0.00	0.00	0.01			0.00	0.01	0.00	0.01			0.01*	0.01	0.01*	0.01
			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)			(0.01)	(0.02)	(0.01)	(0.02)
Num.Obs.	1815	177	1820	178	1815	177	1815	177	1820	178	1815	177	1815	177	1820	178	1815	177	1815	177	1820	178	1815	177
R2	0.017	0.042	0.157						0.075	0.168	0.117	0.016	0.027	0.122	0.018	0.131	0.058	0.008	0.073	0.093	0.022	0.096	0.106	0.011	0.028	0.080	0.015	0.090	0.043
R2 Adj.	0.014	0.014	0.155						0.059	0.165	0.075	0.014	-0.001	0.120	0.001	0.127	0.013	0.006	0.045	0.092	0.005	0.092	0.063	0.008	-0.001	0.079	-0.002	0.086	-0.003

* p < 0.05, ** p < 0.01, *** p < 0.001

Table A10 OLS regression of COVID-19 containment and prevention policy preferences on cultural worldviews and demographic variables. Categorical variables are all dichotomous with reference category in parentheses. Cultural worldview items are centered and standardized such that each has a mean of 0 and a standard deviation of 1

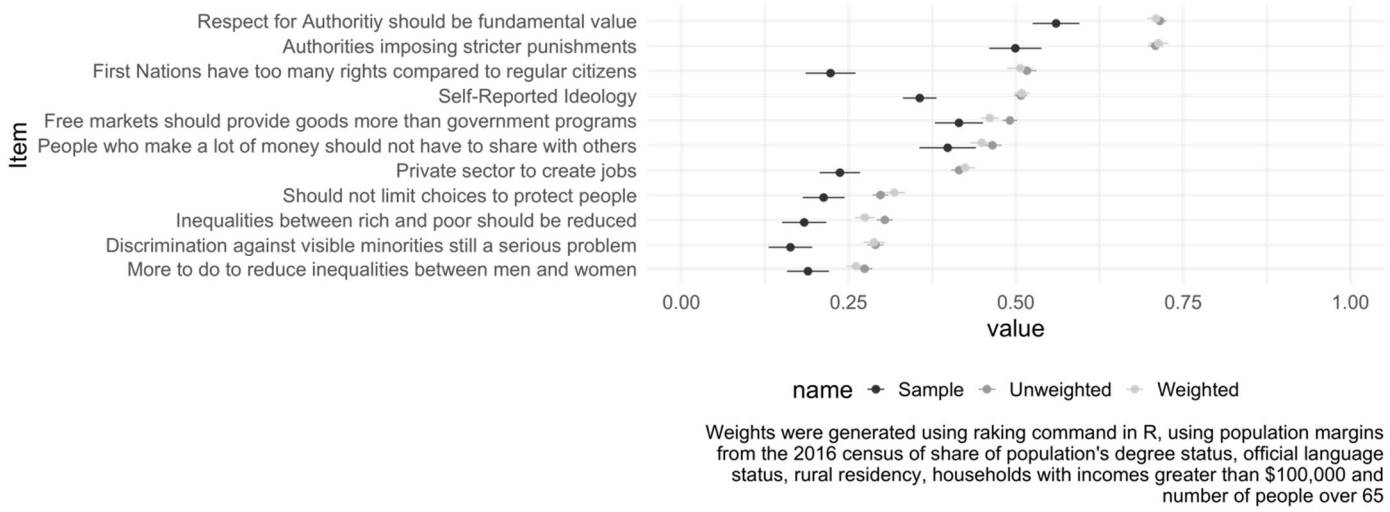

Fig. A1 Comparison of public health sample worldviews with weighted and unweighted general population scores.

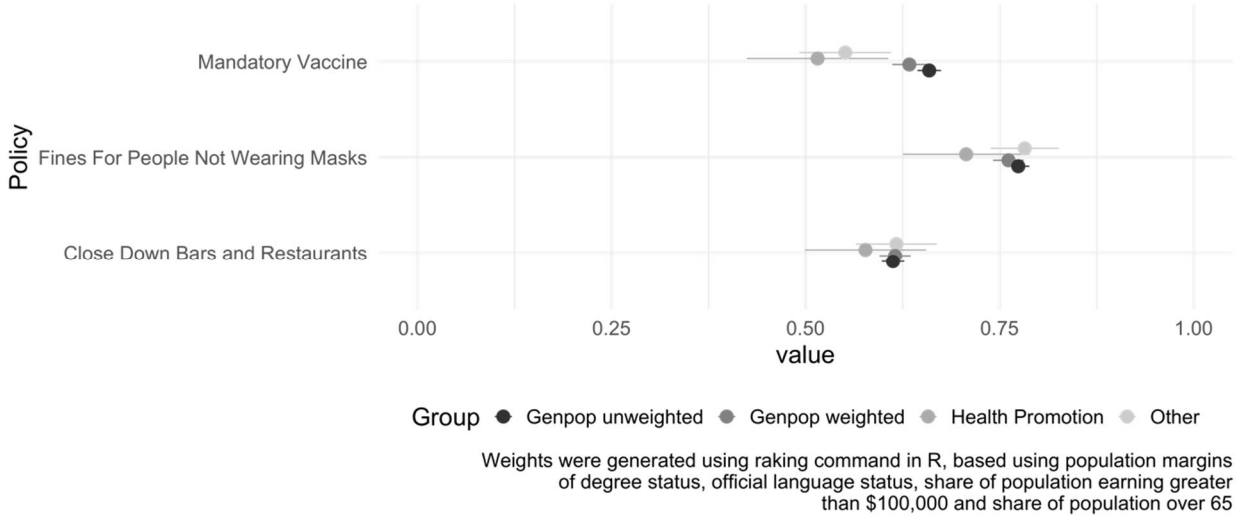

Fig. A2 Comparison of public health sample worldviews with weighted and unweighted general population scores.

Other Findings We Could Add

1. Public health sample is more "technocratic"

Sample	Average
Public Health - Health Promotion	3.9
Public Health - Other	4.0
General Population	4.5

Average responses to question what should dictate public policy, 1=Public policy should be based on the best available scientific evidence 7 = Public policy should be determined by many factors including scientific evidence.

2. Difference in important issues by public health field (see next page)

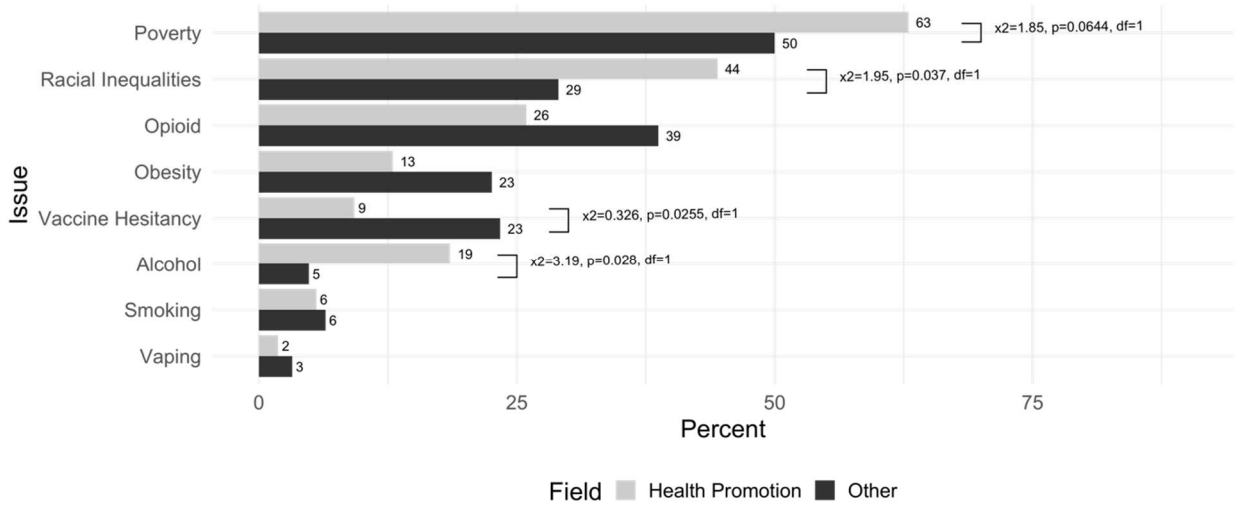

Fig. A3 Comparison of public health sample worldviews with weighted and unweighted general population scores

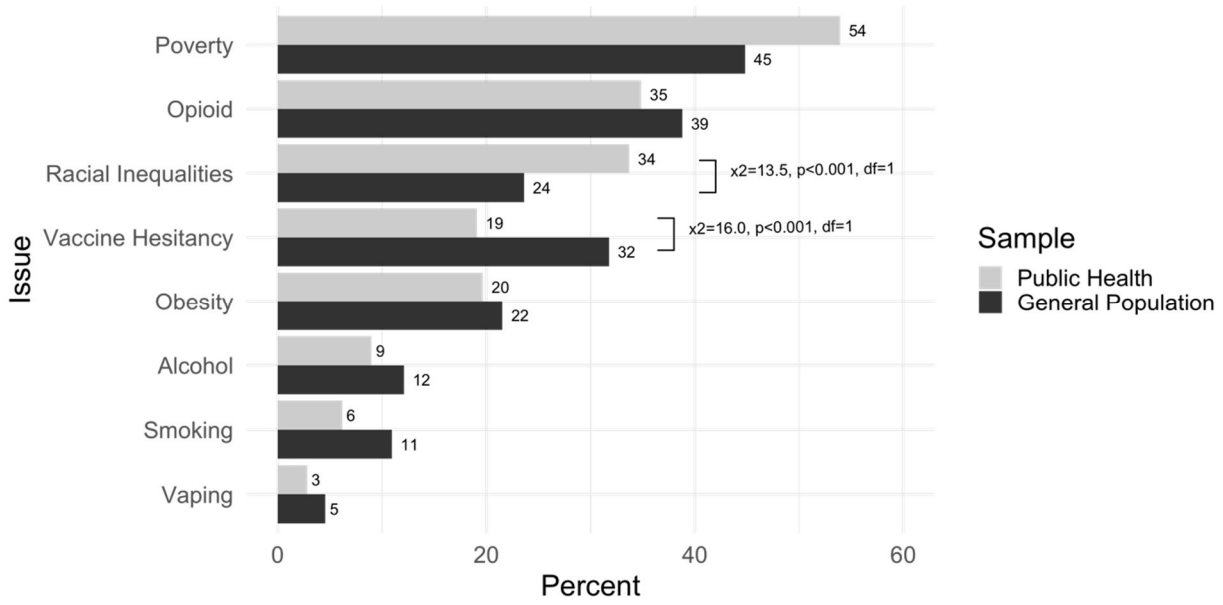

Fig. A4 Comparison of public health sample worldviews with weighted and unweighted general population scores

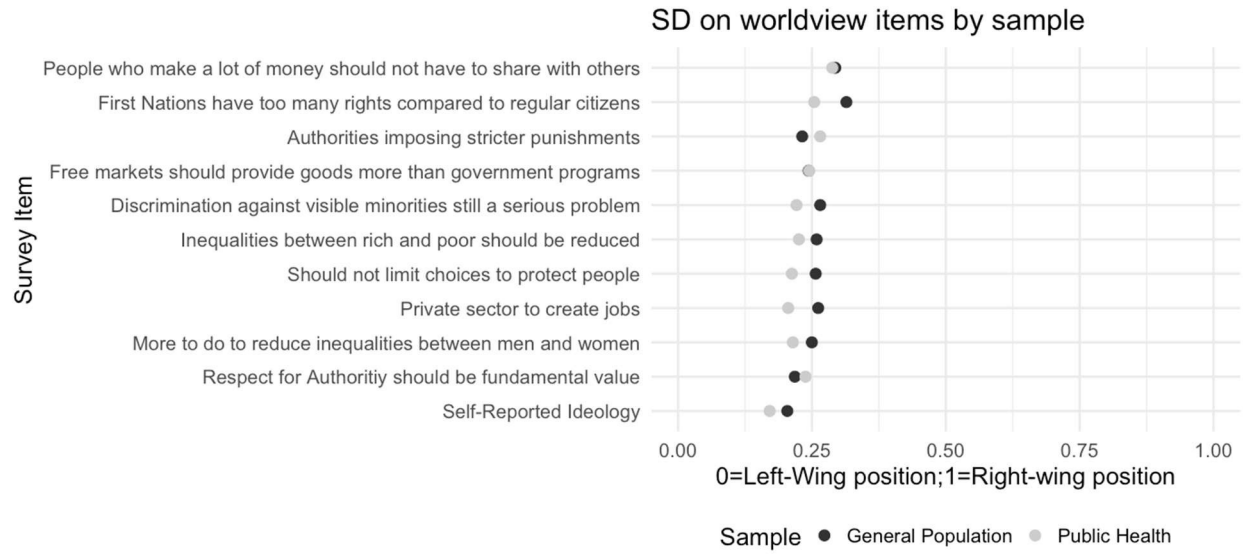

Fig. A5 Comparison of public health sample worldviews with weighted and unweighted general population scores