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# Policy Approaches to Reducing Health Inequalities

March 14, 2017

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Val Morrison  
National Collaborating Centre  
for Healthy Public Policy



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# NCCHPP Team for today's webinar

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Michael Keeling



# Declaration of real or potential conflicts of interest

Presenter:  
Val Morrison



I have no real or potential conflict of interest related to the material that is being presented today.



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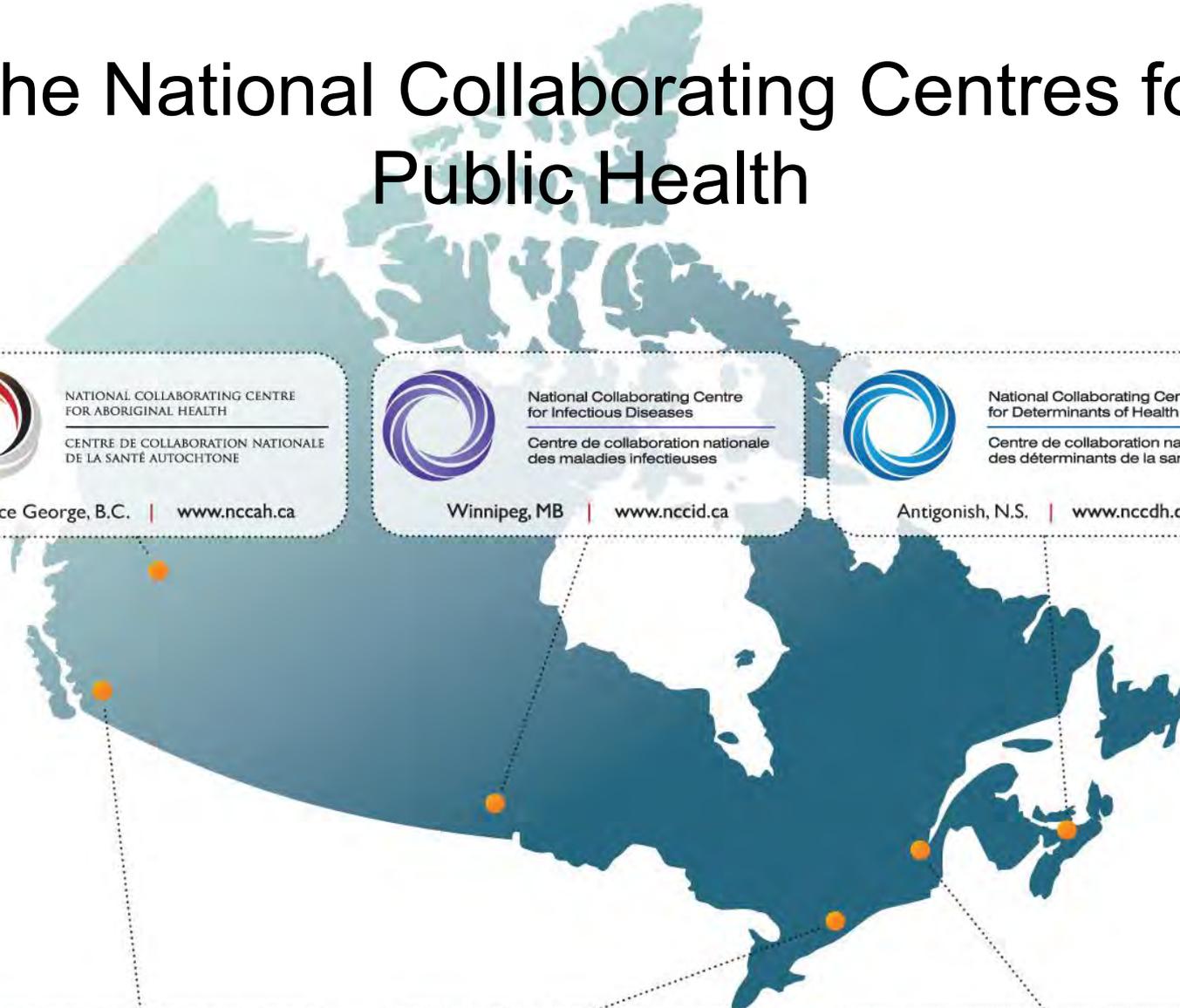
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## Our mandate

- Support public health actors in their efforts to promote healthy public policies

## Our areas of expertise

- The effects of public policies on health
- Generating and using knowledge about policies
- Intersectoral actors and mechanisms
- Strategies to influence policy making



# Policy Approaches to Reducing Health Inequalities

March 2016

## Briefing Note

For up-to-date knowledge relating to healthy public policy

### Introduction

This document is intended to enable public health actors to more easily distinguish between the most widespread policy approaches that have been proposed to reduce health inequalities. The approaches that we will discuss are:

- Political economy,
- Macro social policies,
- Intersectionality,
- Life course approach,
- Settings approach,
- Approaches that aim at living conditions,
- Approaches that target communities, and
- Approaches aimed at individuals.

Health inequalities<sup>1</sup> are understood to be unfair and systematic differences in health among and between social groups – differences which need to be addressed through action. These result from social and political circumstances and are therefore potentially avoidable. To address these inequalities, the relationships between the determinants of health and the health of the population have been brought to the fore so as to direct political action, which can include programmatic intervention at several levels. Despite repeated calls for more action at the structural level and despite political recognition of the importance of this type of action for reducing health inequalities (Popay, Whitehead, & Hunter,

<sup>1</sup> The Government of Canada defines health inequalities as “differences in health status experienced by various individuals or groups in society. These can be the result of genetic and biological factors, choices made or by chance, but often they are because of unequal access to key factors that influence health like income, education, employment and social supports” (Government of Canada, 2008, p. 5). While the term health inequities is often used in the literature, we have used health inequalities here as in other documents by the National Collaborating Centre for Healthy Public Policy (NCCCHPP). (Note: all of our documents are produced in both French and English and there has not yet been a widely agreed-upon translation of health inequalities into French (the WHO Commission reports on the social determinants of health, for example, use health inequities in English and inégalités en santé in French). For clarity and consistency, we use health inequalities in English and inégalités de santé in French.

2010), in reality, for various ideological, historical or practical reasons (Baum, 2011; Baum & Fisher, 2014), policies have more generally aimed at promoting healthy lifestyles and behaviour (e.g., the tax credit promoting physical activity for children in families). This tendency to recognize the need to act on the more structural determinants of health inequalities but to instead develop interventions targeting the more behavioural determinants of health is sometimes called ‘lifestyle drift.’ This has heightened the individualization of responsibility for health (Baum & Fisher, 2014; Baum, 2011) and in some cases, limited the reduction of inequalities or even, led to their intensification (Scott-Samuel & Smith, 2015). There is also a preponderance of policies targeting individuals and communities that are already disadvantaged rather than an attempt to reduce inequalities across the gradient. Such policies limit action that effectively reduces health inequalities throughout the population (Popay et al., 2010).

Our goal is to clarify how the different broad approaches to addressing inequalities are grounded theoretically and how they affect inequalities differently. To better understand the different potential impacts of these approaches, which we briefly define in the text, we shed some light on three interrelated dimensions that are often overlooked or misunderstood.

First, we discuss three ways of conceiving of and describing health inequalities: targeting disadvantaged groups, closing gaps, or addressing the gradient. Secondly we clarify the distinction between the types of determinants (of health or of health inequalities) that may be targeted by the various approaches to reducing health inequalities. Thirdly, we describe the approaches and present them in relation to the type of determinant (of health or of health inequalities) they mainly tackle. Finally, using the categories proposed by Solar and Irwin (2010), we consider the different potential effects (on social stratification, on exposure to risk factors, on the vulnerability of certain groups to particular conditions, and on the inequitable consequences



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# Our objectives today

- Understand the difference between the social determinants of health and the social determinants of health inequalities.
- Differentiate between eight policy approaches to reducing health inequalities.
- Illustrate the practical implications of different policy approaches.



# Health Inequalities

“Differences in health status experienced by various individuals or groups in society. These can be the result of genetic and biological factors, choices made or by chance, but often they are because of unequal access to key factors that influence health like income, education, employment and social supports”

(Government of Canada, 2008, p. 5)

## Lifestyle drift

Recognize the need to act on the more structural determinants of health inequalities but develop interventions targeting individual and behavioural determinants of health.

(Mantoura & Morrison, 2016; Baum & Fisher, 2014)

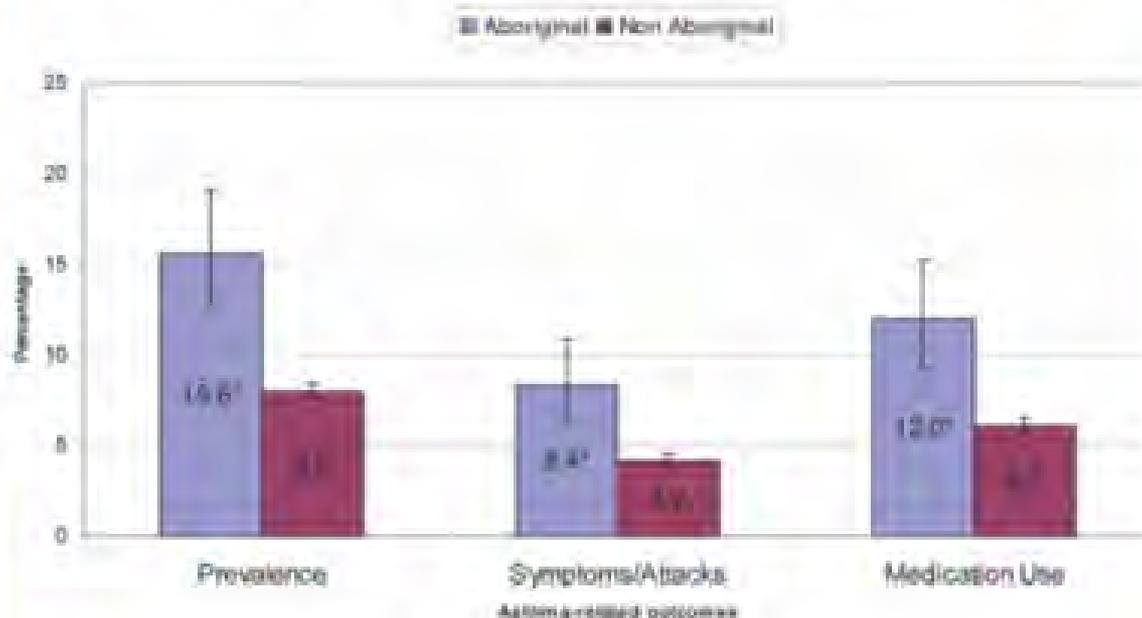
# Health inequalities

- Focus on:
  - Disadvantages
  - Gaps
  - Gradient

(Graham, 2004a)

# Health inequalities in Canada

Figure 11: Asthma Burden by Aboriginal Status, Ontario, 2007-08

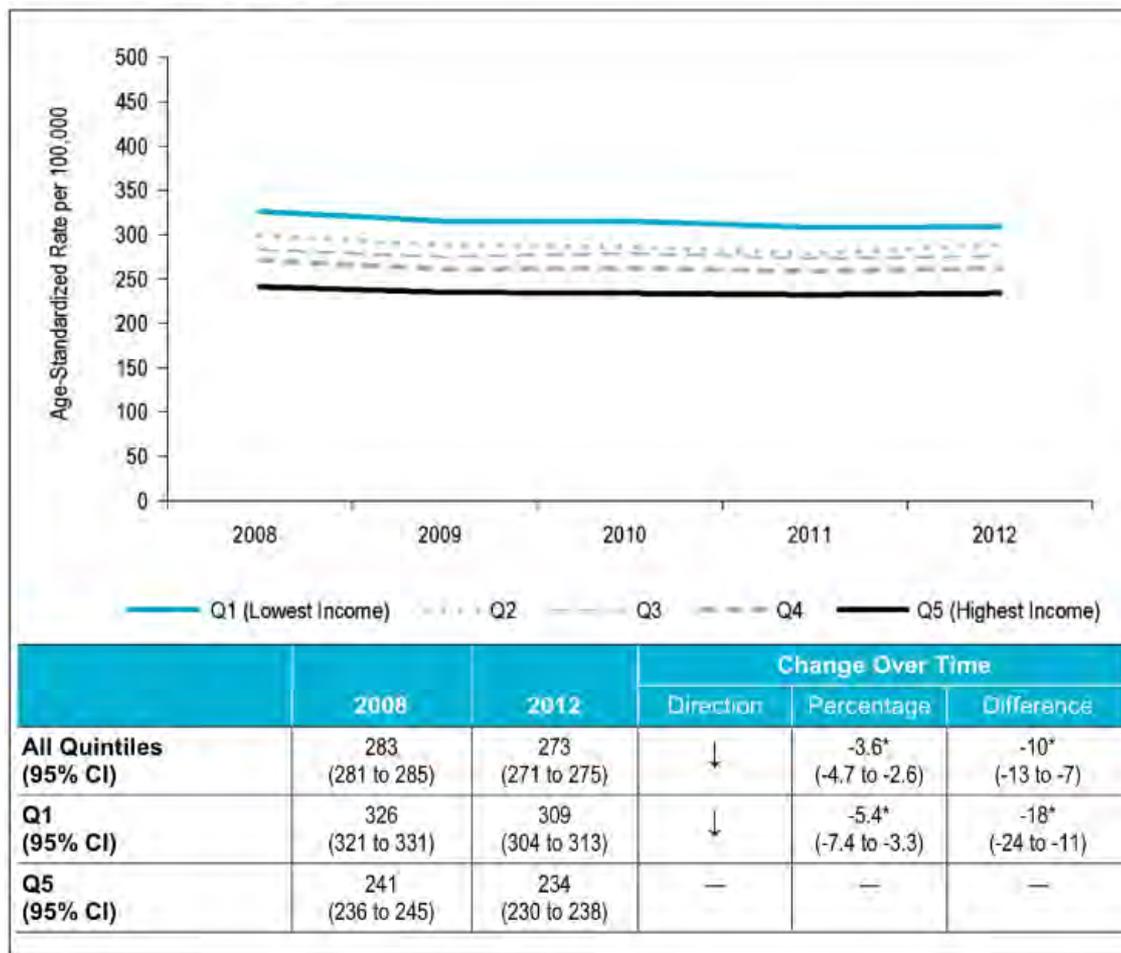


Notes: \*statistically significantly higher

Source: Canadian Community Health Survey, Statistics Canada, Share File, Ontario MOHLTC

# Health inequalities in Canada

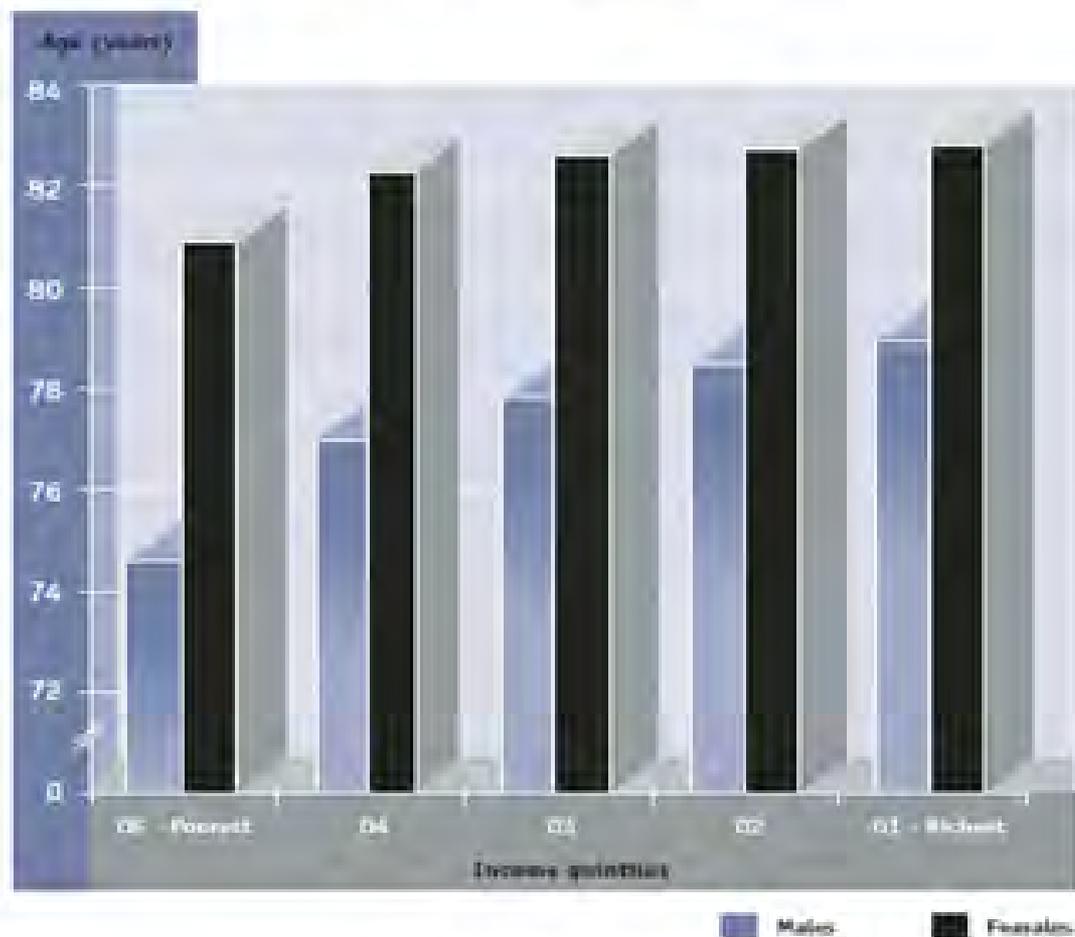
Figure 73: Hospitalized Heart Attacks Rates, by Income Quintile, Canada, 2008 to 2012



(CIHI, 2015)

# Health inequalities in Canada

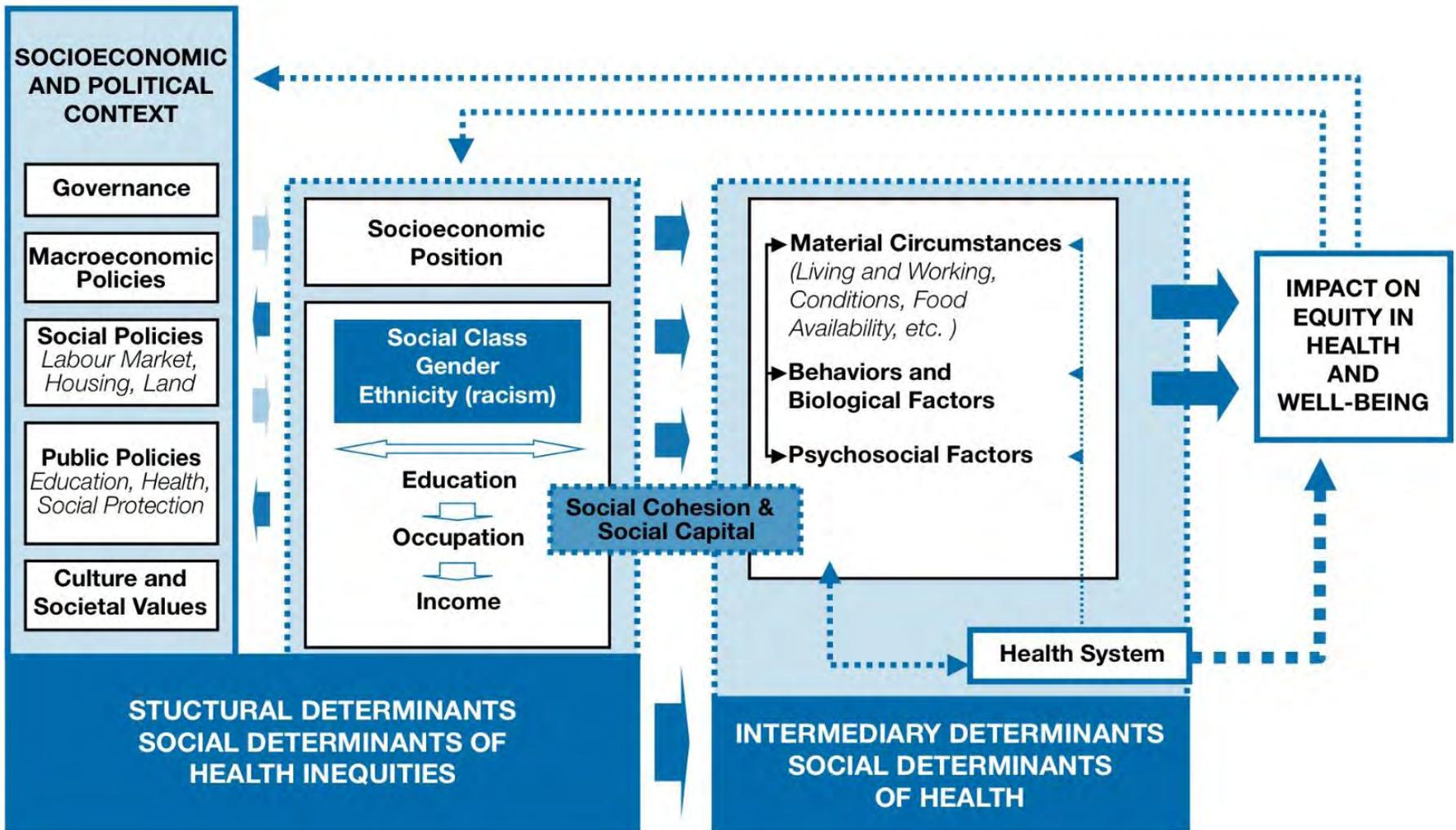
Figure 3.3 Life expectancy at birth by neighbourhood income and sex, urban Canada, 2001



(CPHO, 2008, as quoted by)

# Question

- If you could focus on one single thing to reduce health inequalities in Canada, what would it be?
  1. Nutritional support during pregnancy and early childhood of vulnerable individuals.
  2. Guaranteed annual income for all Canadians.
  3. Improved access to food banks across the country.



(Solar & Irwin, 2010)

## Social determinants of health inequalities

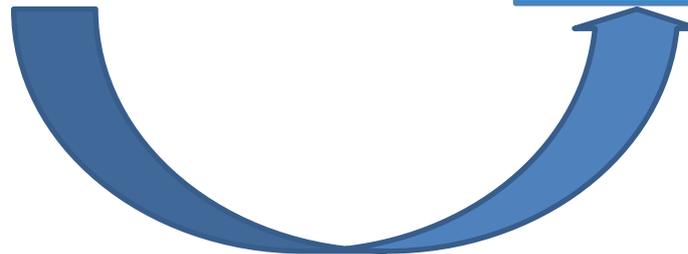
The underlying social structures and processes that systematically assign people to different social positions and distribute the social determinants of health unequally in society.

(VicHealth, 2015, p.6)

## Social determinants of health

The circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics.

(CSDH WHO, 2016)



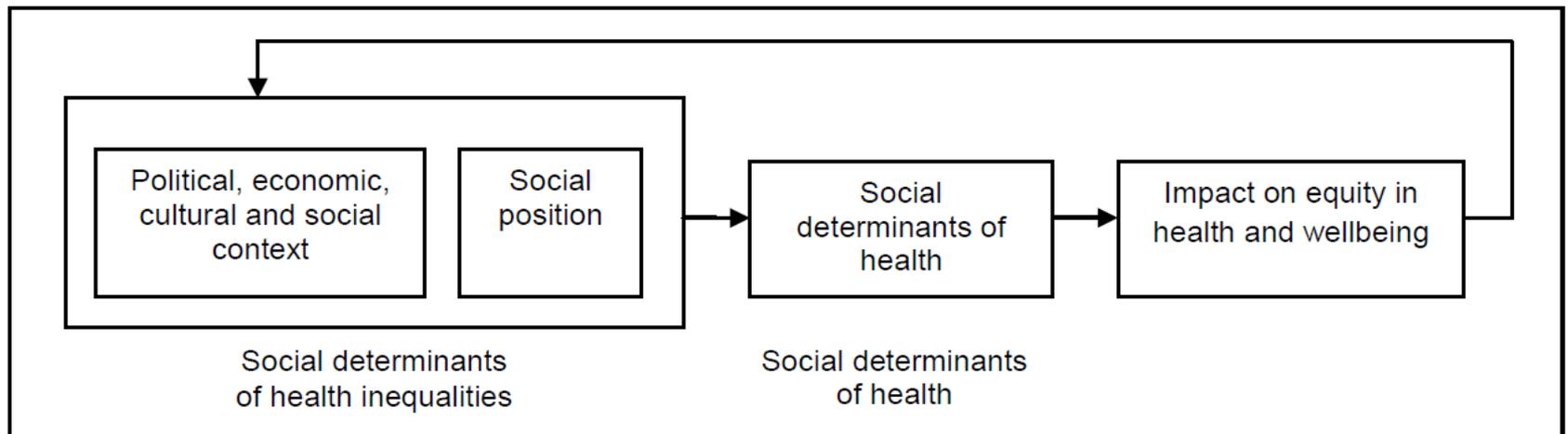
# Reducing health inequalities

Requires a focus on:

The entire health gradient.

The social determinants of health inequalities.

# Social determinants of health and of health inequalities



**Figure 1 Social Determinants of health and of health inequalities**

Source: Adapted from the conceptual framework of the CSDH WHO, 2008

# 8 Policy Approaches

- Political economy
- Intersectionality
- Macrosocial
- Lifecourse
- Living conditions
- Settings
- Communities
- Individuals

# **Key questions about policy approaches to reducing health inequalities**

How is inequality conceived of?

How does the approach explain health inequalities?

What does the approach focus on?

What are the strengths and limitations of each approach?

**Approaches targeting the social determinants of health inequalities (socioeconomic & cultural context, social position).**

Policy approaches for acting on HI	How is inequality conceived of and from which disciplines has the approach emerged?	How does the approach explain health inequalities?	What does the approach focus on?	What are the strengths and limitations of the approach?	Examples
<b>Political economy</b>	<p>Inequality is the result of macro policies on wealth distribution, financial/market regulation, labour law, etc. (structural determinants and the economic organization of society).</p> <p>Inequality is a characteristic of society (not simply between individuals).</p> <p>Focus is on the distribution of power and the relationship of groups and individuals to economic modes of production.</p> <p>Social sciences, esp. political science, sociology, communication studies.</p>	<p>The structural determinants of health inequalities favour the interests of dominant groups at the expense of all others.</p> <p>Health inequalities are the inevitable outcome of social inequality that has its roots in the political and economic distribution of power.</p>	<p>Main focus is on macro or structural level policies</p> <p>Fiscal policies</p> <p>Labour market policies</p> <p>Market regulation.</p> <p>Broad policies that define the structures of governance and nature of polity.</p> <p>As political economy seeks to approach inequalities at their structural roots, it is most likely to intervene at the level of the structures which create stratification (and thus modify social position and the resulting vulnerabilities and exposures).</p>	<p><b>Strengths:</b> Involves intervening at structural levels likely to have repercussions all the way through the social system.</p> <p><b>Limitations:</b> Many health actors feel they are not in a position to influence root causes of inequality.</p> <p>For many, this perspective may represent an unattainable ideological shift.</p>	<p>Type of political and economic systems favoured by states.</p> <p>Types and degree of market regulation.</p>

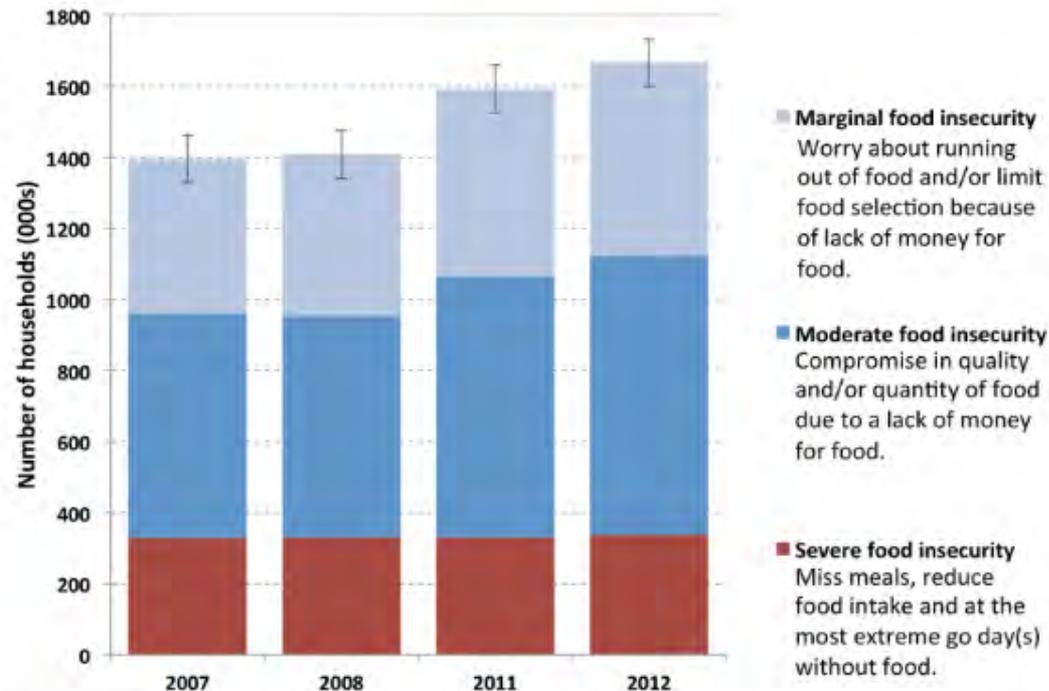
Policy approaches for acting on HI	How is inequality conceived of and from which disciplines has the approach emerged?	How does the approach explain health inequalities?	What does the approach focus on?	What are the strengths and limitations of the approach?	Examples
<p><b>Life course</b></p>	<p>Inequality is imprinted in the life course. It is the result of interactions throughout life between individuals, their choices and their ability to act, and, social structures, the sources of inequality.</p> <p>This approach stems from the intersection of several disciplinary fields, such as sociology, psychology, demography, economics and history, and from research in the field of social epidemiology.</p>	<p>Health inequalities result from variations in the set of factors that protect health or put it at risk that one is exposed to throughout life. These risk factors vary according to social position, local and national living context, the social ties formed during the life course, the life course of linked lives and the opportunity to benefit from support resources.</p>	<p>Policies act at several levels at once and are rooted in social contexts.</p> <p>They target social circumstances and provide support during transitions and shocks throughout life (short-term immediate support and preventive policies) and foster human capital, building on pre-existing assets (long term).</p> <p>They seek to mitigate exposure and vulnerability throughout the life course.</p> <p>Because they have the potential to alter trajectories, they also have the potential to affect the social position of individuals and of those close to them (linked lives, intergenerational impact).</p>	<p><b>Strengths:</b> Allows the life trajectories of different social groups to be taken into account (immigrants, Indigenous persons, etc.), as well as the role of policies in influencing these trajectories.</p> <p><b>Limitations:</b> Difficult to assess the role played by policies during the life course.</p> <p>Requires <u>intersectoral</u> action throughout the life course.</p> <p>Requires participation of marginalized communities in policy making and institutional flexibility.</p>	<p>Preventive policies (short term): universal access to health care (limits the financial shock associated with a serious illness), detection of maternal depression.</p> <p>Human capital policies (long term): early childhood development, high quality daycare, more flexible organizational policies more favourable to youth employment.</p>

Policy approaches for acting on HI	How is inequality conceived of and from which disciplines has the approach emerged?	How does the approach explain health inequalities?	What does the approach focus on?	What are the strengths and limitations of the approach?	Examples
<p><b>Individuals</b></p>	<p>Health inequalities are the result of individual choices and characteristics. They are considered "functionally necessary and inevitable in a complex society that calls upon a wide variety of skills and responsibilities" [translation] (McAll, 2008, p. 94).</p> <p>These approaches emerge from fields such as social psychology or social marketing. They target individual actions and choices, in particular.</p>	<p>The poor health of some groups is exacerbated by modifiable behavioural risk factors, which stem from personality traits or from personal deficiencies (lack of knowledge or education, individual cognitive limitations, etc.).</p>	<p>Encourage individuals to make "healthy choices."</p> <p>Strengthen, support and educate the most vulnerable people to help modify their health-related behaviours and to empower them.</p> <p>These policies attempt to reduce exposure to harmful behaviours.</p>	<p><b>Strengths:</b> Easy to implement and evaluate. Less costly, politically and economically.</p> <p><b>Limitations:</b> Often target only disadvantaged groups.</p> <p>Can blame and stigmatize individuals and increase inequalities when they consider the individual in abstraction: do not take into account socio-cultural or economic limitations or those due to developmental influences associated with a bad start in life. Do not consider the better opportunities that the more advantaged have for adopting the measures dictated by healthy strategies.</p>	<p>Policies promoting information campaigns aimed at preventing obesity or encouraging smoking cessation. Also included here are social marketing policies aimed at modifying health behaviours.</p>

Question or comments?

# Exercise – Policy Approaches

## Household Food Insecurity in Canada 2012



Data Source: Statistics Canada, Canadian Community Health Survey (CCHS), 2007, 2008, 2011 and 2012.

# High food prices could spell big trouble for food banks

Lower purchasing power, fewer donations and increased demand create a perfect storm

The Canadian Press | Posted: Jan 31, 2016 3:15 PM ET | Last Updated: Feb 01, 2016 11:32 AM ET

## Nearly 40 per cent of Canadian post-secondary students experience 'food insecurity:' study

### High food prices driving some shoppers away from fruits, vegetables study says

Low-income, less-educated and young people more vulnerable to rising prices

The Canadian Press | Posted: Jun 06, 2016 7:31 AM ET | Last Updated: Jun 06, 2016 12:18 PM ET



# Exercise – Policy Advice

As public health actors, you are asked to design policy alternatives to tackle food insecurity in your area. What might these look like from each of these three approaches?

- Individual approach
- Lifecourse approach
- Political economy approach

# Exercise – Policy Advice

- Using the first three questions in the table as a guide, what might your policy advice be?

# Individual approach

- Target individual actions and choices.
- Poor health is exacerbated by modifiable behavioural risk factors.
- Encourages individuals to 'make healthy choices.'
- Strengthen most vulnerable to modify behaviour.

# Lifecourse approach

- Inequality is imprinted in the lifecourse (moments of vulnerability).
- Variations in the set of factors that protect health or put it at risk.
- Target social circumstances and provide support during transitions and shocks throughout life.

# Political economy approach

- Inequality is the result of macro policies on wealth distribution and is characteristic of society rather than individuals.
- Health inequalities are the inevitable outcome of social inequality.
- Main focus is on macro or structural policies (fiscal, labour market, market regulation).

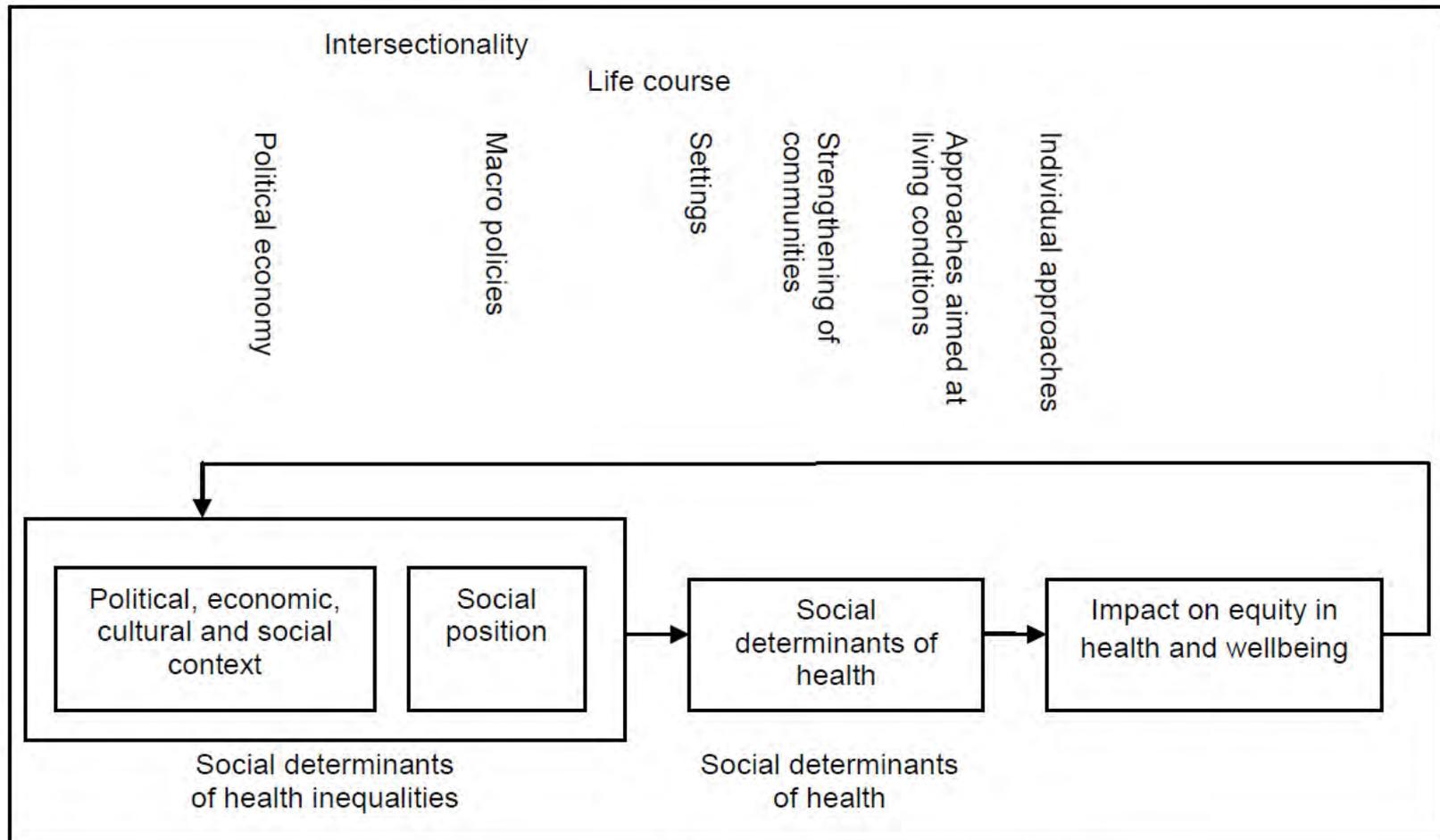
# Ideas?

- Individual?
- Lifecourse?
- Political economy?

# Policies to reduce food insecurity

- Individual: support those suffering (food banks, nutritional information pamphlets...)
- Lifecourse: support those suffering in context and at moments of vulnerability (nutrition programs during pregnancy and early childhood, school lunch programs...)
- Political economy: reduce poverty (universal basic income, labour union-friendly policies...)

# Entry points of policy approaches



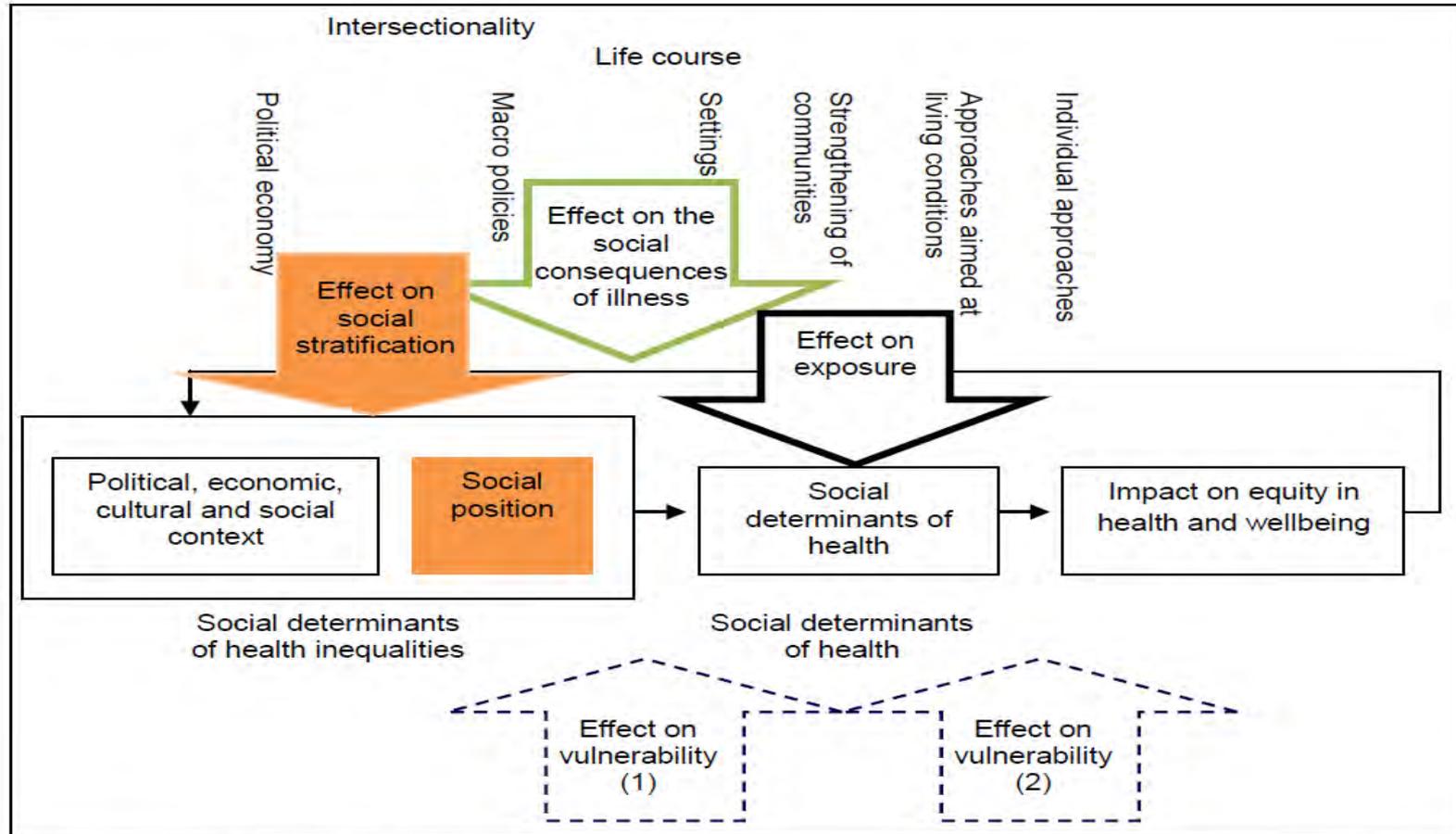
**Figure 2 Entry points of the different policy approaches**

Source: Adapted from the conceptual framework of the CSDH WHO, 2008

# Policy Advice

- Which of the approaches do you think would have the most promising effects on reducing health inequalities?

# Potential impacts



**Figure 3 Potential effects of policy approaches according to their entry points**

Source: Adapted from the conceptual framework of the CSDH WHO, 2008; Solar and Irwing, 2010.

# Conclusion - Summary

- Importance of distinguishing between the social determinants of health and of health inequalities.
- Different policy approaches have different entry points along the continuum.
- These approaches are likely to have different potential effects on health inequalities.

**“Using one model to explain both health and health inequalities can blur the distinction between the social factors that influence health and the social processes that determine their unequal distribution. The blurring of this distinction can be misleading for policy, and feed the policy assumption that health inequalities can be diminished by policies that focus only on the social determinants of health”**

(Graham, 2004b, p. 109).

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