

Policy Approaches to Reducing Health Inequalities

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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 inequalities¹ 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,

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

¹ 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 (NCCHPP). (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 inequities* 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.



of disease) that may be produced by these different approaches.

The approaches are then synthesized and presented for comparison in table form. The table summarizes the different aspects discussed and makes it possible to distinguish at a glance how social and health inequalities are implicitly (or explicitly) conceived of within each approach. It identifies the type of social determinant targeted by each approach (of inequalities or of health), indicates the types of effect that can be produced by these approaches, clarifies the advantages and potential limitations associated with choosing one or the other approach and suggests policy examples.

We base our classification and illustrations largely on reference frameworks (conceptual and action) of the World Health Organization's Commission on Social Determinants of Health (CSDH WHO, 2007, 2008; Solar & Irwin, 2010), along with questions inspired by Whitehead (2007).

In summary

This document is intended to support the work of public health actors by:

- Supporting their understanding of health inequalities and the factors that contribute to them.
- Illustrating the differences between the social determinants of health and the social determinants of health inequalities.
- Showing how different approaches to reducing health inequalities are founded on specific understandings of inequality and that this affects the type of interventions that are possible as well as their likely effects.
- Helping to draw out what kinds of impact they might hope to achieve through the different approaches to reducing health inequalities.

Three ways of considering inequalities

The ways of conceiving of health inequalities and thinking about reducing them exist along a continuum. As such, the objective of reducing inequalities might be pursued by focusing only on improving the health of those in the most disadvantaged groups, by reducing the gap between the most disadvantaged and other groups (usually

either the most advantaged or the average for a population) and finally, by addressing health inequalities across the population. These different ways of conceiving of health inequalities also have wide-reaching policy implications (Graham, 2004a; Graham & Kelly, 2004).

FOCUS ON DISADVANTAGES

One common way to attempt to address health inequalities is to direct policies at the most disadvantaged groups in an attempt to raise their health status. Examples here include the myriad ways that public policies have been applied in an attempt to improve the health of homeless populations. One case is the Ottawa Inner City Initiative. This 2002 program mobilized the federal Supporting Community Partnerships Initiative (part of the federal government's National Homelessness Initiative), the City of Ottawa's Action Plan to End Homelessness, the Ontario Ministry of Health and Long Term Care as well as a number of other public sector resources (at the University of Ottawa and Ottawa Hospital) and non-profit organizations (including many involved with Ottawa's homeless population). Among the health-related initiatives worked out was the MAP (Managed Alcohol Program), designed to specifically address the health problems and needs of homeless alcoholics. This program showed a remarkable reduction of emergency room visits for this (albeit small) disadvantaged population (Podymow, Turnbull, Coyle, Yetisir, & Wells, 2006). A key challenge with this type of policy application is its limited scope. As it applies to a fairly small proportion of the population, even of the disadvantaged population, there is little overall measurable benefit to the health of the overall population. In other words, this type of intervention is an important part of tackling health inequalities, but alone cannot accomplish that goal.

FOCUS ON GAPS

A focus on the gaps that exist in health continues to concentrate on those in the lowest-income groups with poorer health, but specifically in relation to other groups. This approach is exemplified by the common surveillance statistics which focus on the health outcomes of those in the lowest-income (or most disadvantaged) group with either an average for the population or with the health outcomes of those in the highest income (or most advantaged) category. These types of measures have the effect of highlighting the sometimes dramatic health gaps between the least and the most disadvantaged. This

approach continues to focus on the most disadvantaged and as a consequence, tends to ignore not only health inequalities across the health gradient but, more immediately, those in the groups just above the least well off.

FOCUS ON GRADIENT

Approaching inequalities across the health gradient means looking not only at the gaps that exist between those at the top and at the bottom of the scale or at the situation of those most disadvantaged, but also at how health is distributed across all population groups. “It locates the causes of health inequalities not in the disadvantaged circumstances and health damaging behaviours of the poorest groups, but in the systematic differences in life chances, living standards and lifestyles associated with people’s unequal positions in the socioeconomic hierarchy” (Graham & Kelly, 2004, p. 10). Often illustrated with income quintile statistics, we see that those in the group just above the lowest income group have better health outcomes but those just above their group have better overall health outcomes than the second group and so on up to the highest income quintile. This approach aims to keep improving the health of the entire population as it levels out health inequalities across groups. Perhaps the most wide-reaching policy to impact the health gradient in Canada is the Medical Care Act, which introduced universal health care in this country.

In summary

- The literature suggests that improving the health of poor groups and narrowing health gaps are necessary but not sufficient objectives. Reducing inequalities in health ultimately requires a health-gradients approach.
- Interventions targeting the most disadvantaged may appeal to policy makers on the basis of cost or for other reasons. Unfavourable effects of targeted interventions may include:
 - stigmatizing targeted populations (Solar & Irwin, 2010);
 - legitimizing economic disadvantage to make it both more tolerable for individuals and less burdensome for society (Solar & Irwin, 2010); and
 - neglecting people who are “hidden in average data” (who are living in disadvantaged circumstances or come from disadvantaged backgrounds but who are not the target group of the policy or intervention) (Newman, Baum, Javanparast, O’Rourke, & Carlon, 2015).
- Health programs and policies (including those aimed at the social determinants of health) targeting the most vulnerable are important but must not obscure the need to address the structured social inequalities that create health inequalities in the first place (Solar & Irwin, 2010).

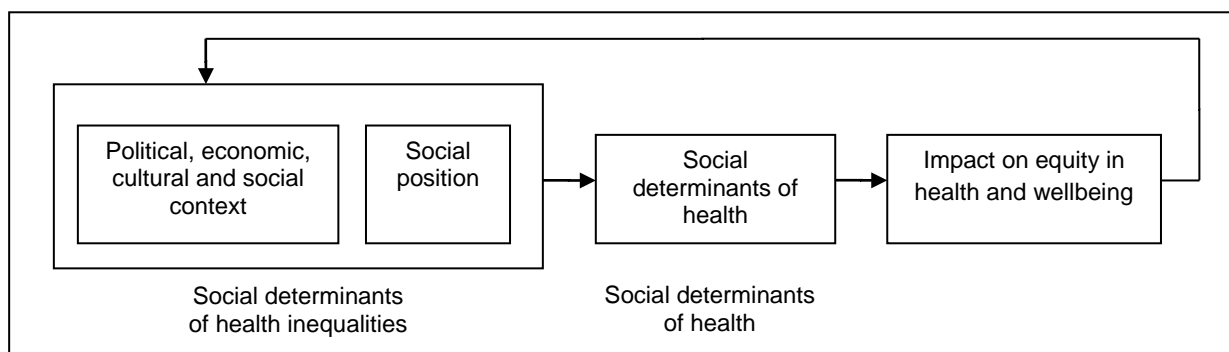


Figure 1 Social Determinants of health and of health inequalities

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

Social determinants of health and of health inequalities

It has come to be commonly accepted that health inequalities are the outcome of an unequal distribution of the social determinants of health and that these determinants are in turn shaped by a wider set of forces: economics, social policies and politics, notably (CSDH WHO, 2008). These wider forces have been identified in the literature variously as the distal, underlying social determinants, the “causes of the causes”, or the structural determinants of health. These factors are the social determinants of health inequalities. Figure 1 is adapted from the conceptual framework of the WHO commission on social determinants of health (2008) (the original framework is reproduced in Appendix 1).

While much work on reducing health inequalities notes the importance of tackling the social determinants of health inequalities, the efforts to reduce health inequalities have mainly concentrated on mitigating the effects of the social determinants of health on different groups in populations.

It has been argued that the use of the same term, “social determinants of health” to identify and tackle both the social determinants of health inequalities, and the social determinants of health often conflates how the two operate (Graham, 2004b).

As Graham noted, the two are best understood as operating quite distinctly, even at times, being at odds with each other. It is possible, for example, to adopt policies aimed at improving the daily living conditions of children from economically disadvantaged backgrounds by, for example, instituting school-based breakfast programs, while at the same time having broader, structural policies which influence the social determinants of health inequalities in such a way that inequality increases in a society. An example of the latter would be social welfare policies which tend to worsen or entrench poverty. In other words, these policies aimed at the social determinants of health may have their positive impacts “mediated by more far-reaching policies: by employment and fiscal policy and by the public provision of education, housing, and social security” (Graham, 2004b, p. 115). One of the main reasons for this lies in how the social determinants of health operate differently from the social determinants of health inequalities.

While poor social and health outcomes may be the result of both, “[u]sing 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).

Successfully reducing health inequalities, then, requires not only addressing the social determinants of health but, crucially, also addressing the social determinants of health inequalities. Approaches which fundamentally address the social determinants of health are therefore best understood as having little impact on the overall distribution of health inequalities throughout a population and are best accompanied by those that attempt to address the social determinants of health inequalities. It is for this reason that we identify the broad approaches discussed here as being primarily ones which fall into one or the other category.

In summary

“The **social determinants of health** are 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).

“The underlying social structures and processes that systematically assign people to different social positions and distribute the social determinants of health unequally in society are the **social determinants of health inequities**” (VicHealth, 2015, p. 6).

Presentation of approaches to reducing health inequalities

In this section, we look at various broad policy approaches that have been used to confront health inequalities. We have organized this presentation around what we’ve called policy *approaches* to reducing health inequalities to highlight the links that exist between broad approaches and likely outcomes related to inequality. The different approaches we have separated in what follows are neither uniform nor necessarily always mutually exclusive. Most of

the categories are deliberately broad and not meant to be exhaustive. Yet, they cover most of the ways of approaching health inequalities with a view to diminishing them. We have deliberately avoided an in depth discussion of specific policy types (universal, targeted, targeted universal, etc. [cf. Carey & Crammond, 2014]) in the hopes of going one step back from that and looking at how each of the approaches conceives of inequality and how this affects the point from which each of them is likely to enter the continuum of how health inequalities come to exist and persist. Our hope is that by categorizing them in this way, we help readers to see how tackling health inequalities from different broad approaches will significantly impact policy entry points and as a result, likely outcomes.

These approaches most often tackle either the social determinants of health inequalities, or the social determinants of health. Depending on the inequality reduction objective pursued (targeted, gaps, gradient) and the manner in which health inequalities are conceived (these underlying conceptions are identified in table 1), certain approaches have been more or less emphasized, alone or in combination with others. For example:

Approaches that target the social determinants of health inequalities (structural determinants of health) may act on the distribution of socioeconomic factors within the population through broad macro social policies such as fiscal policies. These policy approaches often consider that health inequalities are the outcome of social inequalities, and will be more suited (but not necessarily sufficient in and of themselves) to adjusting health levels across the gradient.

Approaches targeting social determinants of health, such as those aiming to improve the quality of neighbourhood environments or public participation in a community, often associate health inequality with limited access to material and psychosocial resources, disadvantage and exclusion; and will most likely seek to help the least well-off members of the population to escape from the situations in which they find themselves. These approaches are more likely to be used to reduce gaps or to target only the disadvantaged (Graham & Kelly, 2004).

Each broad approach comes with similar theoretical and practical baggage (whether explicitly or implicitly) in terms of how inequality is conceptualized and framed, what type of policy is likely to be focused on. Each approach has potential advantages and limitations and these are noted in Table 1.

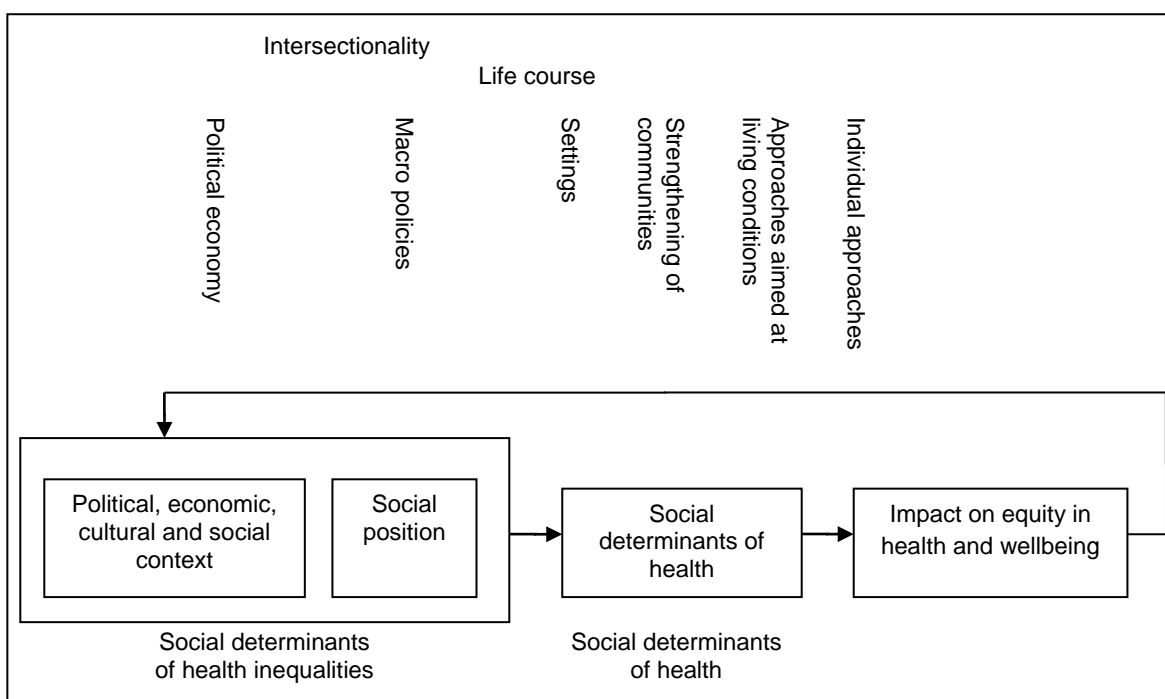


Figure 2 Entry points of the different policy approaches

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

The approaches presented here are classified according to whether they act at a more structural level, by targeting social inequalities through action affecting the social determinants of health inequalities; or whether they act at a more intermediate level, by targeting the social determinants of health. However, some of the approaches presented, such as those focused on intersectionality or on the life course, or those focused on settings and community environments, because of how they conceptualize inequalities, involve interventions that may impact at various steps of the continuum proposed above, even though they may commonly be viewed as more, or less, structural approaches.

APPROACHES THAT ACT *PREDOMINANTLY* ON THE SOCIAL DETERMINANTS OF HEALTH INEQUALITIES

Approaches that act on the social determinants of health inequalities target the social, political, cultural, economic and environmental contexts, as well as the social positioning of groups and individuals within the population. Thus, they have an effect on how the social determinants of health are distributed within the population. These approaches are political economy, macrosocial policies, intersectionality and life course.

Political economy

Political economy refers to a theory and an approach which, when applied to health inequalities, attempts to look at the assumptions and ideologies that underlie political and state structures and the effects that these have on populations. Political economy focuses on power and where it is concentrated in a society and examines how policies tend towards producing and maintaining inequality. Work on health inequalities from this perspective often emphasizes the need to fundamentally alter the nature of the role played by the state in liberal democracies so that it more closely resembles democratic states such as those found in Nordic and Scandinavian countries (Bambra, 2011; Raphael, 2007).

Macrosocial policies

The approaches which focus on macrosocial policies tend to suggest ways of reducing inequality through broad social policies but do not necessarily question the ways in which the structures and ideologies of governance define the extent to which this is possible. These approaches tend to favour policies that provide the conditions concomitant with the

underlying ideological structures of governance of the state (universal health care, in liberal-democracies, for example, or provisions for daycare in social democracies). These universal policies are often seen from this perspective as best applied in combination with provisions targeting the most disadvantaged (Wilkinson & Pickett, 2009).

Intersectionality

Intersectionality is an approach that attempts to deal with multiple intersecting social positions of disadvantage. It was originally conceptualized by Black feminist theorists in the U.S. in the late 1980s as a way of explaining the dual discrimination faced by Black women as something distinct from the simple addition (woman + Black) of two categories of disadvantage. Although this approach originates outside of public health approaches to health inequalities, in recent years it has come to be seen as distinctly useful in designing, analyzing and evaluating public policies, including public health policies (Bowleg, 2012; Hankivsky, 2011; Morrison, 2015). The key to intersectionality is understanding that discrimination and disadvantage operate in distinct ways across social categories to produce intersections that are more or less salient in some places and times.

The life course approach

The life course approach calls for intervention aimed at reducing health inequalities by considering the multiple dimensions of lives as they are actually lived. Additionally, it provides a framework for analyzing the origin of health inequalities that allows for consideration of how exposure to different physical or social risks, both at times of greater vulnerability and throughout the life course, may produce long term effects (latent effects), orient life trajectories (pathway effects) and produce an accumulation of effects (cumulative effects). The life course approach proposes long-term policies that build human capital and short-term policies that support individuals at vulnerable times during the life course. In short, an approach focused on the life course offers the potential to develop public policies which take into account the uniqueness of lives and their trajectories as well as the progress of life calendars (Cooke & McWhirter, 2011; Gaudet, Burlone, & Li-Korotky, 2013; Halfon & Hochstein, 2002; McDaniel & Bernard, 2011; University of Wisconsin-Madison Institute for Research on Poverty, 2005).

APPROACHES THAT ACT *PREDOMINANTLY* ON THE DETERMINANTS OF HEALTH

This category groups together approaches that target living conditions, communities and settings, as well as individuals. These approaches influence the type of resources available in a living environment, access to these resources and their use and health behaviours, and may promote social cohesion, solidarity and participation. They act mainly on the social determinants of health, but are not best suited to reducing the social inequalities underlying health inequalities. They can be conceived of as possible entry points for action on health inequalities as they offer the possibility to reduce gaps and target the most vulnerable. They also may help establish or support a critical mass of individuals able to actively participate in influencing the formulation of policies that are better suited to reducing social inequalities and levelling the distribution of social determinants of health.

Approaches aimed at improving living and working conditions

These target living conditions whose quality diminishes with social position. They target essential programs, services and resources throughout the life course (early child, education, physical environment [neighbourhood recreational resources (parks, sports facilities), the food supply, transportation infrastructure, physical safety, housing, etc.], working conditions, relationships and social norms, health care services, etc.) (VicHealth, 2015; Whitehead, 2007).

Settings approach

The settings approach involves making the environments of people's lives more supportive of health and healthy choices throughout the life course. Ideally, when it involves reducing inequalities in health, the settings approach goes much further than mere individual behaviour change interventions within the setting. It is conceived of as a complex, open and dynamic system. Within this system, the structure and organization of the setting (the social, economic and institutional environments, the organization of the community and of social interaction within the setting) can be targeted so as to create more physical and social resources (structures of opportunity) conducive to better health. At the same time, the ability of individuals to participate in these changes and to take advantage of these new opportunities is also considered and

supported. These approaches, ideally, integrate both individual and structural action, at several levels and in several sectors (Abel & Frohlich, 2012; Bernard et al., 2007; Dooris, 2009; Frohlich & Abel, 2014; Newman et al., 2015; Shareck, Frohlich, & Poland, 2013; Veenstra & Burnett, 2014).

Approaches that target communities

The approaches that target communities generally either consider them as settings "concomitantly the subject and object of [their] transformation" [translation] (Vibert & Potvin, 2012, p. 112), or as productive of local solidarity and as having the power to mobilize and take action (Vibert, 2007). The latter category includes various approaches that view communities as capable of taking into account local realities and of developing innovative local practices within social environments in "partnership" with the government. Here, local community organizations attempt to compensate for the government's limitations by meeting the needs of vulnerable groups in the community; these new forms of solidarity are gradually replacing traditional support networks. Intervention approaches that support social environments (often community development approaches) thereby promote social support, cohesion, inclusion and participation, develop relationships and solidarity and promote local collective action and partnership action which foster autonomy and increase the potential for interaction with the government that is more likely to promote fairer and more responsible policies (Blas et al., 2008; Bourque & Favreau, 2003; Frahsa, Rütten, Roeger, Abu-Omar, & Schow, 2014; Vibert, 2007). These approaches must, however, consider not only the ability of organizational and social structures to facilitate the desired type of participation, but also the long-term sustainability of such opportunities (Popay et al., 2010).

Policy approaches aimed at supporting individuals

These approaches are aimed at developing individual characteristics within certain individuals or groups. They entail strategies aimed at improving knowledge, attitudes or behaviours such as education, literacy, physical activity, individual support, empowerment, the capacity to act, mindfulness, etc. (Baum, 2011; Whitehead, 2007). Within these approaches, the absence of such characteristics is considered to be the cause of the deficiencies or disadvantages within certain groups, for example: limited personal knowledge, certain

beliefs, low self-esteem, low levels of competence or lack of power.

Effects likely to be produced by different approaches to reducing health inequalities

To fully grasp the distinction between approaches that target the social determinants of health inequalities and those that target the social determinants of health, it is useful to see the types of effects likely to be produced represented along that continuum. In Figure 3 below, based on the work of the Commission on Social Determinants of Health (Solar & Irwin, 2010; CSDH WHO, 2007, 2008), we add the type of effects that interventions are likely to have depending on the potential entry point of the approach to reducing health inequalities. The types of effects are defined and discussed below and

visually represented in Figure 3. The specific types of effects linked to each approach to reducing health inequalities are presented in Table 1.

The approaches compared in this document can have, to varying degrees, more or less structural impacts on the exposure of individuals or groups to different factors associated with health. They can have an effect on social stratification, on vulnerability, on exposure to risk factors, and on the consequences of ill health, when it occurs.

Effects on social stratification

Policies that act on social stratification are those which have the greatest impact on the reduction of health inequalities. These are policies that target social inequality. They act on structural determinants (social determinants of health inequalities). They target the socioeconomic and political context of a society and influence the type of political, social, public and other safety nets that are put in place.

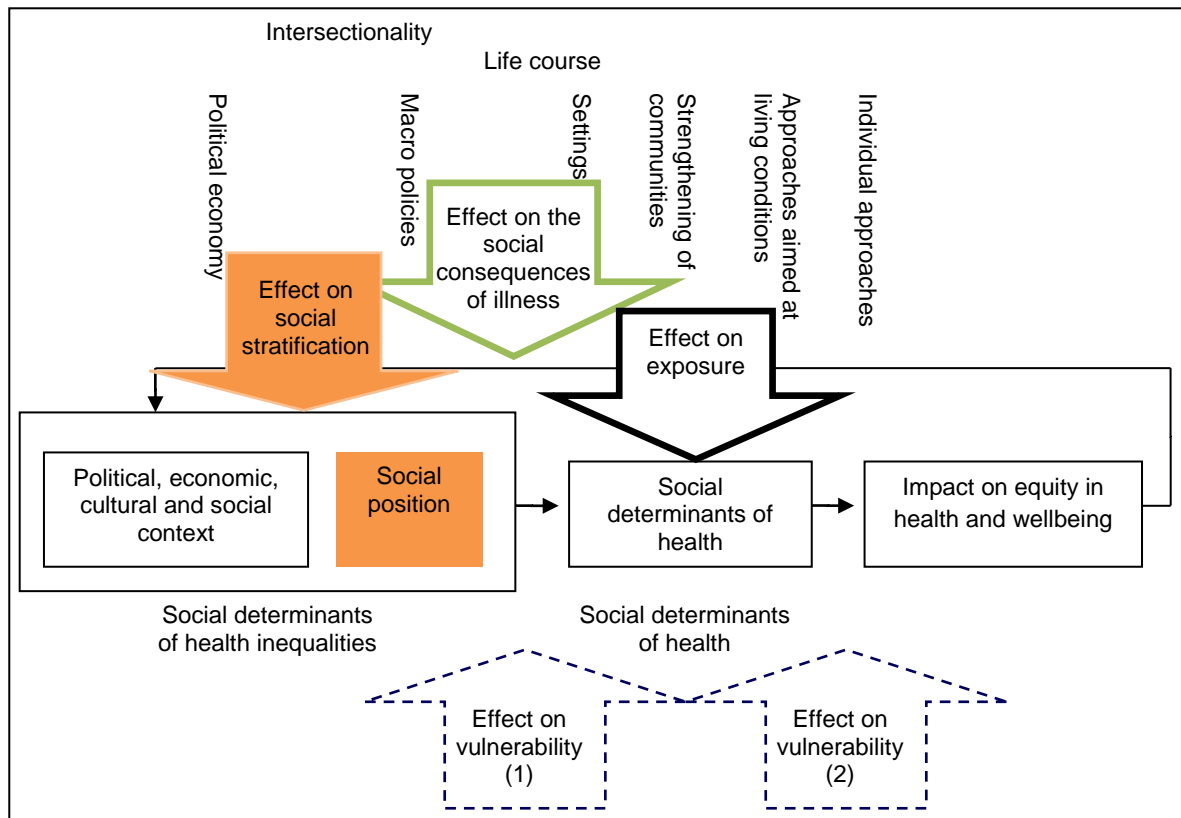


Figure 3 Potential effects of policy approaches according to their entry points

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

This affects the distribution of resources which are associated with social position, such as income, education or immigration status. Included here, for example, are labour and fiscal policies established by government. Tackling inequalities in social position is likely to be at the heart of a strategy aimed at reducing inequalities in health. Social position is the pivotal point in the causal chain linking social determinants of inequalities in health to the social determinants of health (Solar & Irwin, 2010; VicHealth, 2015).

Effects on vulnerability (1)

The political, social and economic context modulates the distribution of different resources and this impacts social position. These positions are inevitably tied to certain vulnerabilities that groups in different social positions are likely to experience (women, immigrants, ethnic minority groups, certain types of workers, etc.) and combine throughout their lives. Policies which seek to minimize the vulnerability of those in disadvantaged social positions include those that combat poverty, policies and programs designed to give disadvantaged children access to increased educational opportunities, or policies that support female education: “one of the most effective means of mediating women’s differential vulnerability” (Solar & Irwin, 2010).

Effects on exposure

Policies that act on the social determinants of health (various environmental or behavioural risk factors), and mediate the relationship between socioeconomic position and health, seek to improve one or more of the living conditions of disadvantaged people and groups. They have an effect on the exposure of disadvantaged individuals or communities to these risk factors. An example would be a policy favouring access to social housing for single mothers. Reducing exposure to one or more risk factors also potentially reduces vulnerability.

Effects on vulnerability (2)

Vulnerability to health-damaging conditions comes from the cumulative and combined effects of exposure to multiple health-damaging factors (poor living conditions, lower educational attainment, inadequate or unsatisfactory work, lack of social network, etc.). This ultimately renders certain individuals and groups more prone to illness. Policies that seek to limit the vulnerability to certain health-damaging conditions address these effects by

providing specific support to groups and individuals in those situations of multiple risks (harm reduction programs for certain drug users, for example). Reduced vulnerability may only be achieved when interacting exposures are diminished or relative social conditions improve significantly (Solar & Irwin, 2010).

Effects on the social consequences of illness

Illness and disability can lead to individuals experiencing increased vulnerability and illness due both to inadequate support systems (including income support, services such as adapted transport or access to flexible employment conditions, for example) and to the tendency for illness and disability to lead to disadvantaged social position in contemporary industrialized societies. In this way, without policies which mitigate this effect, illness, particularly chronic physical or mental illness, and disability feed back into determining social position and thus increasing the health disadvantages of these groups even further. Policies that have effects on the social consequences of illness can stem from various approaches, going from the more macro social policies, to local interventions supporting specific populations. Examples of policies to reduce the social consequences of illness include additional care and support to disadvantaged patients, and additional resources for programs to reduce the effects of illness (physical and mental) on people’s earning potential, living arrangements, social participation and networks or equitable health care financing. “Social consequences of diseases have a much steeper socioeconomic gradient than the incidence and prevalence of the same diseases” (Solar & Irwin, 2010, p. 53).

The majority of interventions aimed at reducing health inequalities have had an impact on the exposure of vulnerable groups to health compromising conditions and factors (neighbourhood safety programs, for example) and on the vulnerability of the disadvantaged to mitigate potential or further exposure to health damaging conditions (adequate social security for seniors, for example). Further, most interventions have been designed to intervene in one area at a time (income or housing or behaviour or education, etc.) and very few are designed to reduce health inequalities by aiming at several factors at the same time. Fewer still have truly taken aim at the social determinants of health inequalities (reducing poverty, for example).

Some definitions:

“The process by which individuals become assigned to different positions in the social hierarchy is known as social positioning, or **social stratification**” (VicHealth, 2015, p. 5). Social positioning within stratification systems plays a large role in determining access to resources, power and the social conditions which favour access to health benefitting factors.

“Social stratification [...] engenders differential **exposure** to health-damaging conditions and differential **vulnerability**, in terms of health conditions and material resource availability” (Solar & Irwin, 2010, p. 8).

(Differential) exposure refers to the social complexion of experience such that one person’s experience of things will differ from that of another insofar as the two persons occupy differently advantaged positions within the socioeconomic order. For example, people living in low socioeconomic status (SES) communities typically experience greater exposure to fast-food outlets by virtue of the relatively high density of such outlets in low SES areas (VicHealth, 2015, p. 14).

(Differential) vulnerability may be impacted at two moments along the continuum (Solar & Irwin, 2010, p. 53):

1. The first effects concern vulnerability understood as the conditions that existed previous to specific exposures (Solar & Irwin, 2010).
2. The second effects concern vulnerability as it refers to “the socially based experience of harm, or the proneness to chronic illness that varies according to social position, regardless of the uniformity of risk-factor rates. For example, greater alcohol harms are seen in low SES groups, even though consumption levels are the same across a wide SES spectrum (Makela 1999)” (VicHealth, 2015, p. 14).

(Differential) social consequences of illness:

variability in the tendency for illness and disability to lead to further socio-economic degradation in relation to social position.

Table 1 Summary of policy approaches to reducing health inequalities (HI)

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
Political economy	<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>Strengths: Involves intervening at structural levels likely to have repercussions all the way through the social system.</p> <p>Limitations: 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>
Macrosocial policies	<p>As they refer to a variety of approaches which have in common the level at which they think inequality is best addressed, there is no single disciplinary source. Broadly, both the social and health sciences have focused on macrosocial policies.</p> <p>Inequality is viewed as resulting from the failure to adequately distribute wealth and services in a society. In Canada, this has largely</p>	<p>Membership in certain groups may be more likely to result in wealth related health inequalities (single mothers, for example).</p> <p>Membership in certain groups may make it more difficult to compete on a level playing field and take advantage of health producing services and/or behaviours.</p>	<p>Policies tend to focus on wealth redistribution and be universal in application.</p> <p>Arguments are often for strengthening welfare-state supports and some policy suggestions lean towards social-democracy types (universal daycare, for example).</p> <p>Macrosocial policies are most likely to have the effect of reducing social stratification by levelling up the social positions of those in disadvantaged groups.</p>	<p>Strengths: Macrosocial policies have the potential to mitigate the ill effects of inequality before they result in unequal health outcomes.</p> <p>Limitations: May be limited by the political/economic orientation of states and governments (cf., distinctions in Esping-Anderson, 1990).</p> <p>Public health actors may feel they have limited influence over these types of policies.</p> <p>Change may be slow.</p>	<p>Universal health care; child tax credits; social welfare policies, etc.</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
Macrosocial policies (cont'd)	meant a commitment to liberalism and its democratic value of "equality of opportunity" and remaining inequality may be viewed as a result of the inability or the lack of willingness to take the necessary steps to succeed.				
Intersectionality	<p>Intersectionality examines context-specific intersections of social locations.</p> <p>Inequality results from multi-dimensional (disadvantaged) social locations: race, gender, age, immigration status, sexual orientation, etc.</p> <p>Inequality is conceived of as oppression vs. privilege.</p> <p>Emerged in the late 1980s in the social sciences and humanities.</p>	<p>These intersections of disadvantage result in unequal access to health producing factors (wealth, prestige, power, etc.).</p> <p>Oppression is viewed as causing distinct negative health outcomes.</p>	<p>Interplay of various social locations – requires paying close attention to who is or might be disadvantaged by policy / program choices.</p> <p>Policies that use this approach have the potential to reduce stratification and are likely to reduce vulnerabilities of social position as well as of exposure and exposure to health damaging factors itself.</p>	<p>Strengths: Aims to address inequalities as they are lived by individuals and groups.</p> <p>Seeks to address more than one source of disadvantage and its effects.</p> <p>Limitations: Fairly new and can seem too overwhelming in scope to be considered.</p> <p>Many actors may feel this is beyond their scope/capacities.</p>	Homeless shelters/housing options specifically for LGBT street youth.
Life course	<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, those being 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</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</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>Strengths: 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>Limitations: Difficult to assess the role played by policies during the life course.</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</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
Life course (cont'd)	research in the field of social epidemiology.	of linked lives and the opportunity to benefit from support resources.	They seek to mitigate exposure and vulnerability throughout the life course. 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).	Requires intersectoral action throughout the life course. Requires participation of marginalized communities in policy making and institutional flexibility.	employment.
Approaches targeting the social determinants of health (living environment, settings, communities and individuals).					
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
Living conditions	<p>These approaches conceive of inequality as resulting from differential access to material and psychosocial resources, which is structured by belonging to different social classes or by having different socioeconomic statuses.</p> <p>Broadly, both the social and health sciences have focused on the importance of living conditions. Historically, interventions aimed at improving living conditions have also embodied the main current of thought within public health (such as the provision of safe drinking water or sewage disposal), and have been fundamental to improving the health of populations.</p>	Poor health is associated with adverse living conditions, reduced access to essential services and resources in many spheres of life (family, work, community, etc.) and with exposure to psychosocial stress (insecurity, lack of control over one's life, stigmatization, feelings of exclusion, of isolation, etc.).	<p>Policies are aimed at improving physical environments or the characteristics of social environments.</p> <p>They seek to reduce vulnerability and exposure to adverse living conditions and psychosocial stress among various population groups.</p>	<p>Strengths: May be universal and improve the health of all or may target the most disadvantaged sectors, thus doing more to improve the health of the most vulnerable.</p> <p>Limitations: Potential to exacerbate inequalities, if applied alone, because the variable use made of such measures by different groups is often not taken into account.</p> <p>Often target only one living condition at a time.</p> <p>Not enough attention to more structural determinants underlying the adverse conditions in different living environments.</p>	<p>Policies aimed at improving working conditions in disadvantaged employment sectors (low-status jobs).</p> <p>Policies that focus on social housing.</p> <p>Policies that promote healthy workplaces.</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
Settings	<p>Inequality is a reflection of the interaction between the setting context and the individuals that compose it.</p> <p>These approaches are traditionally inspired by the ecological model of health promotion, and through a complex systems perspective. More recently they are supported by contemporary sociological theories, critical realism and the capability approach.</p>	<p>The exacerbation of poor health in certain settings along with unhealthy behaviours are influenced by many interacting factors, including the physical aspects of the environment (such as the natural and built environments), social and collective factors (current norms and values, organizations and communities) and the opportunity for/ability of people to draw on available resources.</p>	<p>Policies aim to modify the structural dimensions of an environment <i>and</i> to support the ability of individuals to take advantage of these structural dimensions and to have an impact on them. The environment's resources are not ends in themselves, but rather means of achieving goals.</p> <p>These interventions call for policy intervention at several levels.</p> <p>They seek to reduce exposure to a variety of risk factors within a setting as well as reduce the vulnerability of certain social groups.</p>	<p>Strengths: Act simultaneously at several levels to reduce exposure to adverse conditions and support the ability to act individually and collectively to promote health.</p> <p>Limitations: Requires in-depth knowledge (social and political analysis) of settings and their various sub-populations.</p> <p>The long-term participation of the most marginalized groups can be difficult to sustain.</p> <p>Requires extensive cross-sectoral action/cooperation.</p> <p>Challenges powerful players, so requires much planning, commitment and committed leadership.</p> <p>Crucial that they work “both upwards and outwards” (Dooris, 2009, p. 32).</p>	<p>Policies favouring an integrated approach; multi-setting implementation of programs.</p> <p>Policies targeting the participation of marginalized groups in the development and implementation of programs and research within settings (Healthy Cities movement).</p>
Communities	<p>Inequality is the result of differing access to sources of power, which limit what people are able to do and to be.</p> <p>These approaches are rooted in theories of power, of social movements, of informal reciprocity and of collective action and organization.</p>	<p>The poor health of some groups is exacerbated by processes of exclusion, isolation and lack of power. This obstruction of the opportunity to participate socially deprives certain groups or communities of dignity, self-esteem and control or influence over their lives.</p>	<p>Policies aim to develop social cohesion, mutual support, participation, empowerment, collective action, community development and local communities' influence over public policies and decision-making processes.</p> <p>They reduce exposure and vulnerability by facilitating social integration and participation, and can</p>	<p>Strengths: Better meets the needs of local communities (participation in decision making and in evaluating interventions). Builds local capacity and strengthens community wellbeing.</p> <p>Limitations: Often targets only certain disadvantaged communities. Requires participation, partnership and intersectoral collaboration.</p>	<p>Participatory budgeting promotes the exercise of citizenship and collaborative decision making aimed at choosing the range of public services to be offered (McKenzie, 2014).</p> <p>The Montréal local social development initiative involves a negotiated agreement between the city of Montréal, the Montreal public health authority,</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>Communities (cont'd)</p>			<p>theoretically have an effect on stratification, since they are intended to facilitate the implementation and choice of more equitable, broad social policies.</p>	<p>Risks placing too heavy a burden on local organizations and disadvantaged persons, without ensuring the necessary flexibility within structures to enable/support this emerging local collective action. So, there may be little critical questioning of entrenched inequalities.</p>	<p>Centraide of Greater Montréal (United Way) and the Montréal Regional Coalition of Neighbourhood Organizations (Neighbourhood networks on the island of Montréal), and aims to promote a process of citizen participation in order to reduce health inequalities at the local level. Supports the efforts of local communities rather than the implementation of a pre-planned program (Bernier, Clavier, & Giasson, 2010).</p>
<p>Individuals</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>Strengths: Easy to implement and evaluate. Less costly, politically and economically.</p> <p>Limitations: Often target only disadvantaged groups. 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>

Conclusion

With this document, we have set out to shed some light on the ways that various broad policy approaches attempt to account for and address health inequalities. While it is widely understood within public health generally (and particularly among those who work in the areas of the social determinants of health and health inequalities) that addressing inequalities is best done at the level of the social determinants of health inequalities, the majority of attempts to address these have been and continue to be focused on downstream determinants and particularly on individual behavioural determinants. This has meant that health inequalities between social groups, although they have been the focus of much work for well over twenty years, have not been substantially reduced, and in many cases, have in fact increased (Scott-Samuel & Smith, 2015). By concentrating on where they are situated along

the continuum of social determinants of health inequalities - social determinants of health, we can see where the policy approaches are likely to intervene and what we might expect their effects to be. Whether they are likely to address stratification, reduce vulnerability and exposure to health damaging factors, or mitigate the effects of ill health, we hope to have pointed out, in fairly broad strokes, how each approach, whether individually or in combination, might contribute to reducing health inequalities. The list of approaches described and situated here is not exhaustive but we believe we have covered most of the dominant approaches to health inequalities in public health literature and practice. Ultimately, we hope to have helped to show where the various broad approaches concentrate their efforts and what the advantages and limitations of each of these might be.

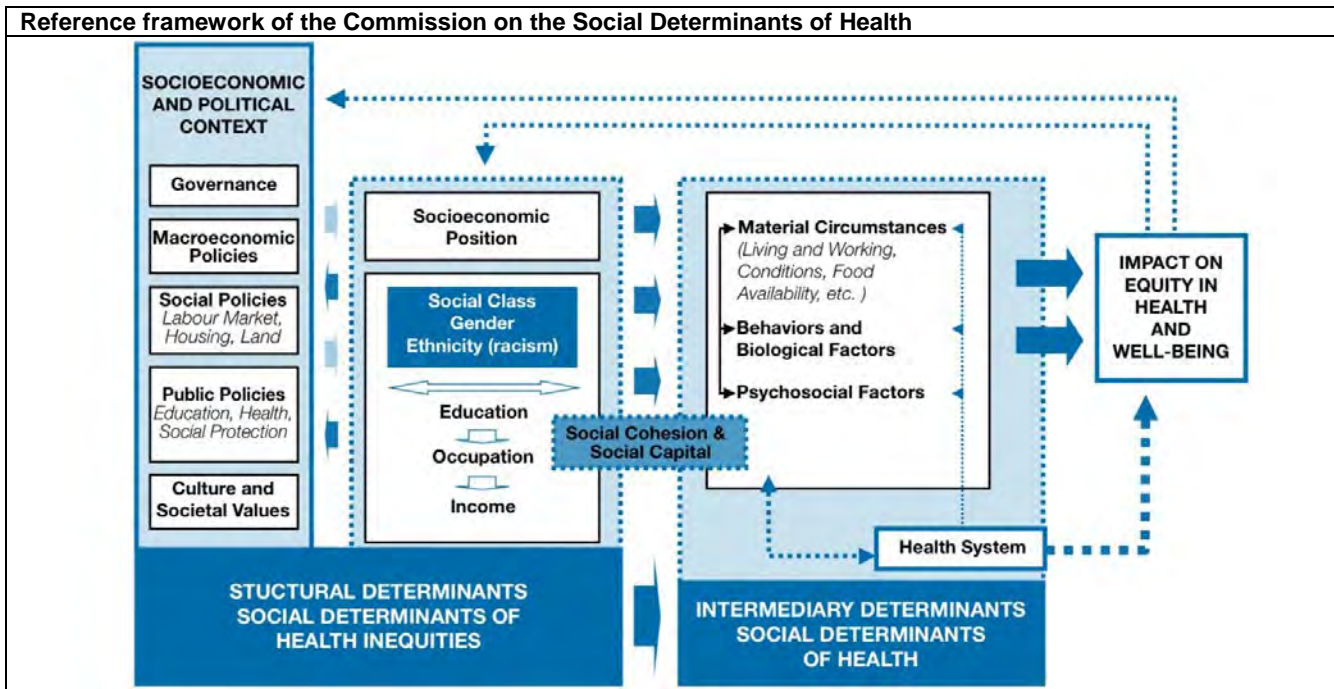
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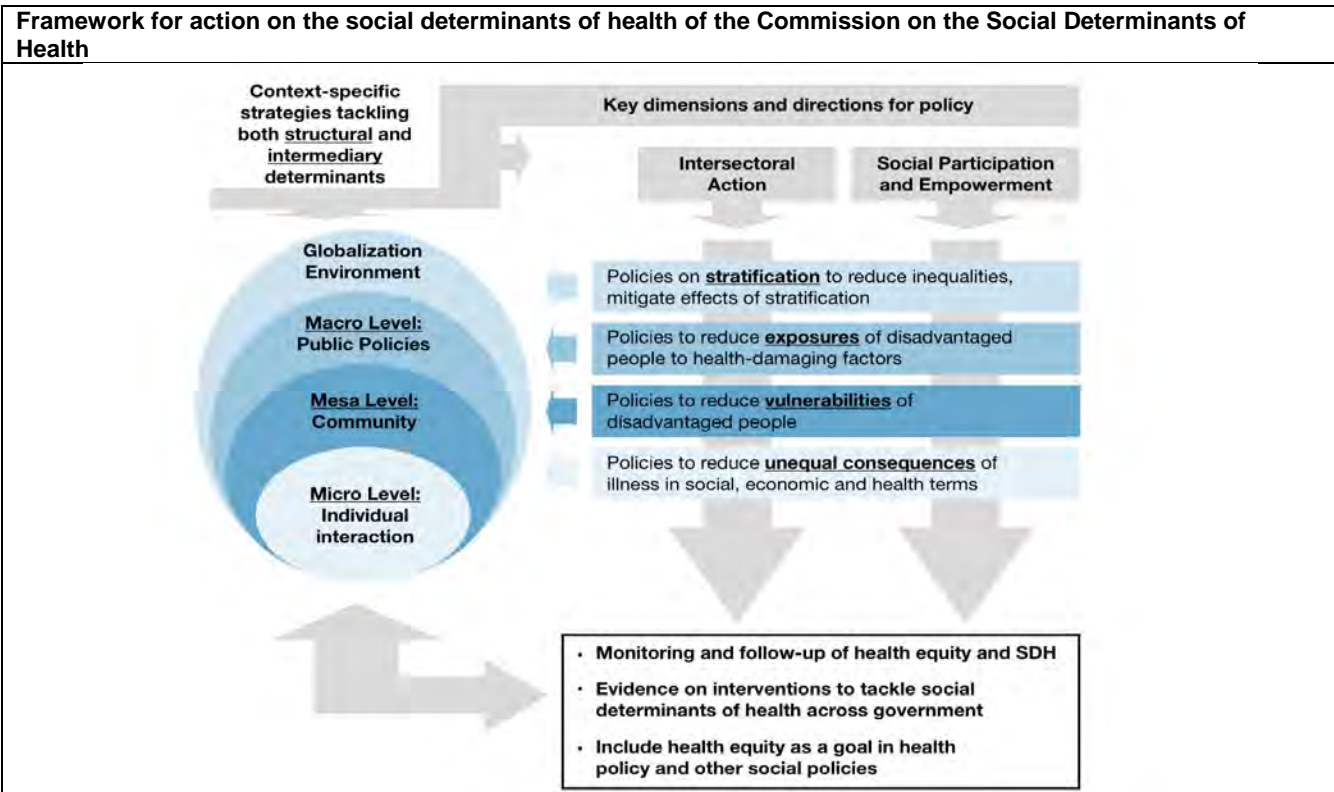
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Appendix 1 Frameworks from the Commission on the Social Determinants of Health



Reprinted from Solar & Irwin, A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2, p. 48, World Health Organization (2010).



Reprinted from Solar & Irwin, A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2, p. 60, World Health Organization (2010).

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