Summary of policy approaches to reducing health inequalities

March 2016

The table presented here is intended to be used to facilitate thinking about the questions presented in the document *Policy Approaches to Reducing Health Inequalities: A practical exercise using the example of food security* (available at: https://www.ncchpp.ca/141/Publications.ccnpps?id_article=2031).

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Summary

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

Centre de collaboration nationale sur les politiques publiques et la santé
National Collaborating Centre for Healthy Public Policy

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Approaches targeting the social determinants of health inequalities (socioeconomic & cultural context, social position).					
Policy approaches for acting on health inequalities (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	Inequality is the result of macro policies on wealth distribution, financial/market regulation, labour law, etc. (structural determinants and the economic organization of society). Inequality is a characteristic of society (not simply between individuals). Focus is on the distribution of power and the relationship of groups and individuals to economic modes of production. Social sciences, esp. political science, sociology, communication studies.	The structural determinants of health inequalities favour the interests of dominant groups at the expense of all others. Health inequalities are the inevitable outcome of social inequality that has its roots in the political and economic distribution of power.	Main focus is on macro or structural level policies Fiscal policies Labour market policies Market regulation. Broad policies that define the structures of governance and nature of polity. 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).	**Strengths:** Involves intervening at structural levels likely to have repercussions all the way through the social system. **Limitations:** Many health actors feel they are not in a position to influence root causes of inequality. For many, this perspective may represent an unattainable ideological shift.	Type of political and economic systems favoured by states. Types and degree of market regulation.
Macrosocial policies	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. Inequality is viewed as resulting from the failure to adequately distribute wealth and services in a society. In Canada, this has largely	Membership in certain groups may be more likely to result in wealth related health inequalities (single mothers, for example). 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.	Policies tend to focus on wealth redistribution and be universal in application. Arguments are often for strengthening welfare-state supports and some policy suggestions lean towards social-democracy types (universal daycare, for example). Macrosocial policies are most likely to have the effect of reducing social stratification by levelling up the social positions of those in disadvantaged groups.	**Strengths:** Macrosocial policies have the potential to mitigate the ill effects of inequality before they result in unequal health outcomes. **Limitations**: May be limited by the political/economic orientation of states and governments (cf., distinctions in Esping-Anderson, 1990). Public health actors may feel they have limited influence over these types of policies. Change may be slow.	Universal health care; child tax credits; social welfare policies, etc.

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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	Intersectionality examines context-specific intersections of social locations. Inequality results from multi-dimensional (disadvantaged) social locations: race, gender, age, immigration status, sexual orientation, etc. Inequality is conceived of as oppression vs privilege. Emerged in the late 1980s in the social sciences and humanities.	These intersections of disadvantage result in unequal access to health producing factors (wealth, prestige, power, etc.). Oppression is viewed as causing distinct negative health outcomes.	Interplay of various social locations – requires paying close attention to who is or might be disadvantaged by policy / program choices. 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.	**Strengths**: Aims to address inequalities as they are lived by individuals and groups. Seeks to address more than one source of disadvantage and its effects. **Limitations**: Fairly new and can seem too overwhelming in scope to be considered. Many actors may feel this is beyond their scope/capacities.	Homeless shelters/housing options specifically for lgbt street youth.
Life course	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. This approach stems from the intersection of several disciplinary fields, such as sociology, psychology, demography, economics and history, and from	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	Policies act at several levels at once and are rooted in social contexts. 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).	**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. **Limitations**: Difficult to assess the role played by policies during the life course.	Preventive policies (short term): universal access to health care (limits the financial shock associated with a serious illness), detection of maternal depression. Human capital policies (long term): early childhood development, high quality daycare, more flexible organizational policies more favourable to youth

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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).					
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Living conditions	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. 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.	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.).	Policies are aimed at improving physical environments or the characteristics of social environments. They seek to reduce vulnerability and exposure to adverse living conditions and psychosocial stress among various population groups.	**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. **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. Often target only one living condition at a time. Not enough attention to more structural determinants underlying the adverse conditions in different living environments.	Policies aimed at improving working conditions in disadvantaged employment sectors (low-status jobs). Policies that focus on social housing. Policies that promote healthy workplaces.

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Settings	Inequality is a reflection of the interaction between the setting context and the individuals that compose it. These approaches are traditionally inspired by the ecological model of health promotion, and a complex systems perspective. More recently they are supported by contemporary sociological theories, critical realism, and the capability approach.	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.	Policies aim to modify the structural dimensions of an environment *and* 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. These interventions call for policy intervention at several levels. They seek to reduce exposure to a variety of risk factors within a setting as well as reduce the vulnerability of certain social groups.	**Strengths**: Act simultaneously at several levels to reduce exposure to adverse conditions and support the ability to act individually and collectively to promote health. **Limitations:** Requires in-depth knowledge (social and political analysis) of settings and their various sub-populations. The long-term participation of the most marginalized groups can be difficult to sustain. Requires extensive cross sectoral action/cooperation. Challenges powerful players, so requires much planning, commitment and committed leadership. Crucial that they work "both upwards and outwards" (Dooris, 2009, p. 32).	Policies favouring an integrated approach; multi-setting implementation of programs. Policies targeting the participation of marginalized groups in the development and implementation of programs and research within settings (Healthy Cities movement).
Communities	Inequality is the result of differing access to sources of power, which limit what people are able to do and to be. These approaches are rooted in theories of power, of social movements, of informal reciprocity, and of collective action and organization.	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.	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. They reduce exposure and vulnerability by facilitating social integration and participation, and can	**Strengths**: Better meets the needs of local communities (participation in decision making and in evaluating interventions). Builds local capacity and strengthens community well-being. **Limitations**: Often targets only certain disadvantaged communities. Requires participation, partnership and intersectoral collaboration.	Participatory budgeting promotes the exercise of citizenship and collaborative decision making aimed at choosing the range of public services to be offered (McKenzie, 2014). The Montréal local social development initiative involves a negotiated agreement between the city of Montréal, the Montreal public health authority,

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Communities (cont'd)			theoretically have an effect on stratification, since they are intended to facilitate the implementation and choice of more equitable, broad social policies.	l 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.	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).
Individuals	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). These approaches emerge from fields such as social psychology or social marketing. They target individual actions and choices, in particular.	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.).	Encourage individuals to make "healthy choices." Strengthen, support and educate the most vulnerable people to help modify their health-related behaviours and to empower them. These policies attempt to reduce exposure to harmful behaviours.	**Strengths:** Easy to implement and evaluate. Less costly, politically and economically. **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.	Policies promoting information campaigns aimed at preventing obesity or encouraging smoking cessation. Also included here are social marketing policies aimed at modifying health behaviours.

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March 2016

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Editing: Marianne Jacques, National Collaborating Centre for Healthy Public Policy

SUGGESTED CITATION

Mantoura, P. & Morrison, V. (2016). *Summary of policy approaches to reducing health inequalities*. Table taken from the document *Policy Approaches to Reducing Health Inequalities*. Montréal, Québec: National Collaborating Centre for Healthy Public Policy.

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Production of this document has been made possible through a financial contribution from the Public Health Agency of Canada through funding for the National Collaborating Centre for Healthy Public Policy (NCCHPP). The views expressed herein do not necessarily represent the views of the Public Health Agency of Canada.

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