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Policy Avenues: Interventions to reduce social inequalities in health

SYNTHESIS

Québec

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Background

This summary review focuses on the subject of social inequalities in health (SIH) and on public policies implemented in Québec and elsewhere in the world aimed at reducing these inequalities. It was produced by the Équipe politiques publiques [public policy team] of the Institut national de santé publique du Québec (INSPQ) [Québec's public health expertise and reference centre] and is based on a longer document. Its principal aim is to present a selection of government interventions that could help guide the Québec government toward the improvement or development of interventions that are aimed at reducing SIH or that indirectly contribute to their reduction. To this end, this document identifies examples of policies, strategies, laws, action plans and programs that constitute options or avenues that could prove inspiring. The main implementation conditions and the effectiveness or impact of these interventions are examined where data are available. Given the scope of the problem of combating SIH, this review focuses, with few exceptions, on central government interventions, even though many promising and relevant interventions aimed at reducing SIH emanate from the regional and local levels, or from still other sources, such as the community or private sectors.

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Highlights

- Various social factors, such as education, income, work, living environment, housing and access to services, determine an individual's state of health. These interact in varying combinations throughout the life course. Inequitable distribution of these factors, or health determinants, among groups generates considerable health differences among people within a community or a country, or between countries. The gaps or unequal distribution of health status, linked to these determinants within a population are referred to as social inequalities in health (SIH). Inequalities are not inevitable and could be reduced, according to the World Health Organization. The problem of social inequalities in health is vast and complex: unequal power dynamics and exclusion, as well as certain policies and social norms and practices generate social and health disparities.
- Data on the scope of SIH in Québec speak for themselves. The differences between socioeconomic groups, in terms of life expectancy and premature mortality, are marked. For example, in 2006, the gap in life expectancy between the most disadvantaged and most advantaged segments of the population was 8.1 years for men and 3.9 years for women. Similarly, in the most disadvantaged segment of the population, 93% more individuals did not consider their health to be good, 88% more were daily smokers, 54% more were dissatisfied with their social life and 28% more were obese, as compared with the most advantaged segment. Some population groups, such as Aboriginal peoples, were shown, in certain cases, to be affected to an alarming degree by social inequalities in health.
- Government intervention to reduce SIH is neither simple nor unambiguous, and necessarily involves a group of interventions. Governments have developed different approaches to reducing SIH. Some countries, for example, have adopted a systematic and comprehensive government policy to reduce SIH, while others have instead developed a national public health policy explicitly aimed at reducing SIH, or at addressing the social determinants of health upstream. Implemented in conjunction with these global approaches, a number of sectoral or intersectoral interventions focused on health determinants can contribute significantly to combating SIH.
- There is no scientific consensus regarding how to effectively take action to reduce SIH, although some authors recommend giving priority to interventions that promote more egalitarian access to resources, such as those targeting income, employment, and access to education and services. However, the need to take SIH into account when considering government intervention, at the very least to avoid worsening the situation, is acknowledged by experts. In addition, this review demonstrates that to reduce SIH, social policies must be strengthened both at the level of the general population (universal interventions) and at that of disadvantaged populations (targeted interventions), without stigmatizing the latter. Consequently, proportionately targeted interventions, or actions aimed at the general population, but in conjunction with intervention modulated according to the social gradient of health, should be preferred and strengthened. The review of foreign experiences also helps to identify the conditions most likely to produce promising results, which include the mobilization of different actors around shared priorities for action, citizen participation in interventions, high quality interventions and the integration of services to facilitate their access.
- Québec cannot adopt, at the provincial level, a policy on the same scale as those of several of the countries discussed in this document; it may, however, draw inspiration from them, while taking into account the federal context within which it operates. Québec does not have a policy that specifically or globally targets the reduction of SIH. However, the Québec government has implemented large-scale interventions that address social and economic inequalities by targeting poverty or social exclusion, for example. Some avenues to be explored by the Québec government emerge from this study, including, in particular, the promotion of a shared vision for reducing SIH that mobilizes all government sectors, the strengthening of achievements tied to social protection, to the fight against poverty and to action addressing the determinants of health, the establishment of a monitoring system and the participation of citizens in decision making.

Summary

This document focuses on the subject of social inequalities in health (SIH) and on public policies implemented in Québec and elsewhere in the world aimed at reducing these inequalities. Its principal aim is to present a selection of government interventions that could help guide the Québec government toward the improvement or development of interventions that are aimed at reducing SIH or that indirectly contribute to their reduction. The document firstly presents comprehensive approaches to combating SIH adopted by various countries, then the SIS-related intervention context in Québec and, thirdly, interventions that more specifically target social determinants of health, in Québec and abroad.

Key points to note concerning comprehensive approaches to combating SIH

Several countries, each in accordance with its own political context, have adopted a broad approach to combating SIH that encompasses several sectors of intervention. The United Kingdom, Finland, Sweden, Norway, Australia and New Zealand are recognized for their experience in this area. This overview of foreign experiences reveals that the implementation of comprehensive approaches to combating SIH has most often been the work of governments headed by centrist, labour or social-democratic parties benefiting from political stability. Many of the countries examined were easily mobilized around the issue of SIH, which was aligned with the social values and social protection systems already promoted by these governments. All of the countries discussed recognize the need to work intersectorally to address SIH. The global approaches they have adopted generally fall under the responsibility of their departments of health, who, in almost all cases, have an expanded mandate that includes social services and/or social affairs. The United Kingdom, Finland and New Zealand have established government bodies to oversee intersectoral coordination or introduced advisory mechanisms to ensure the implementation of their policies. The United Kingdom, Sweden and Australia have assigned expert organizations the mandate of carrying out knowledge transfer activities, as well as the monitoring and evaluation of interventions. Several of these countries also make use of health impact assessment. In addition, it appears that regional and local authorities often play a key role in implementing comprehensive approaches, since they are, in many cases, introduced at these levels of governance. This overview highlights some of the conditions that favour implementation of a comprehensive approach to reducing SIH, including political will and stability, the promotion of justice and equity as social values, and intersectoral governance that mobilizes the various sectors and levels of government. However, it also reveals that, on the one hand, the impact of the interventions implemented is not always evaluated and, on the other hand, that the results obtained so far have not always been those expected. Foreign experiences demonstrate, ultimately, that it can be difficult to reach the most disadvantaged populations using only a universal strategy. This type of intervention, which targets the entire population, can increase SIH by more successfully reaching advantaged groups. The challenge is to find a balance between universal measures that affect the entire population and measures that proportionately target disadvantaged groups without stigmatizing them.

SIH in the Québec context

Québec is recognized for having advanced a model of social protection consistent with those that are the focus of discussion in Europe,[1] which distinguishes it within the North American context. However, Québec has not adopted a public policy that specifically or globally targets the reduction of SIH. Nor has it established a formal system for monitoring SIH and, therefore, it has not set specific targets for the reduction of SIH. The Québec government has mainly implemented a series of policies that, although not introduced specifically to combat SIH, may have a real effect on these by targeting one or more determinants of health. The Québec government has also established strategies for supporting intersectoral action that can serve as levers for action in the struggle against SIH.

However, Québec could play a more active role, much like certain European countries that are clearly committed to developing their own social policies. It is well known that many of the measures adopted by the Québec government, such as family allowances, parental leave and the $7-per-day daycare program, protect middle-class families and children.[2] Drug insurance, the work premium, employment support measures, and the indexation of social assistance benefits are other examples of measures identified as having contributed to recent successes. Government maintenance and strengthening of sustained interventions in the areas of social protection and health remains key to reducing SIH.

Key points to note on government interventions focused on determinants

The interventions outlined in this section focus on early childhood and education, employment, income and social solidarity, the environment and land use planning, lifestyle, and health and health services. These determinant-based approaches emanate from various sectors, including that of heath. These types of interventions, for example revenue support or municipality revitalization measures, do not usually focus on SIH or on health. Some measures focus on prosperity or economic development, which obviously have an indirect impact on SIH and on health. Several interventions derived from approaches focused on the living environment, such as community development, affect many determinants and are considered to be intersectoral projects.

This overview demonstrates that mobilization around the interventions adopted is crucial. We can assume that the top priorities adopted by governments and international organizations such as the WHO help foster stakeholder commitment to shared priorities for action, such as fighting obesity or ensuring sustainable development, by affirming the relevance of interventions in such areas. It is interesting to note that a strategic issue such as sustainable development, which aims to promote social and economic prosperity, can align with the fight against SIH, as the United Kingdom and French initiatives clearly show. Intersectoral projects focused on economic development, such as Slovenia's *Programme MURA* (health, agri-food, tourism, and transportation), have resulted in positive benefits for disadvantaged populations.

Several foreign initiatives highlight the relevance of citizen participation in interventions. Accordingly, several projects in England, Spain and Germany have shown that consulting local residents about which interventions to choose and how to implement them not only has a positive effect on community participation and on the ability of interventions to adequately meet needs, it also promotes the social inclusion of disadvantaged populations. Furthermore, these experiences show that citizen participation strengthens social networks.

This summary review also highlights the importance of the quality of the interventions implemented. Creating jobs that are risky or hazardous to health or building low-quality social housing will have little impact on reducing SIH or on health. In terms of housing, for example, the Welsh Housing Quality Standard proved very useful for improving tenant health, and in the early childhood services sector, foreign experiences show that the quality of daycare services and interventions for disadvantaged children is crucial. In addition to the requirements concerning quality, it appears that integrated services are often needed to ensure improved access for disadvantaged segments of the population; coherence among the different services for vulnerable people is fundamental to ensuring their participation in these interventions.

Finally, two challenges appear to be associated with interventions targeting determinants of health, and these tie in with those identified for comprehensive approaches. Firstly, the scarcity of results regarding the impact of these interventions on health and on SIH makes prioritizing the most effective interventions very difficult. Secondly, effectively reaching the most vulnerable segments of the population is also difficult, given that these individuals rarely use public services, even when the services are free and easily accessible. Actions specifically targeting disadvantaged neighbourhoods (*MURA*, *North Karelia Project*) have produced noteworthy results in terms of promoting healthy lifestyles. This type of targeted strategy nonetheless runs the risk of creating stigmatization, which can, however, be lessened by focusing on a community sector, rather than on a socioeconomic group much like the United Kingdom's *Sure Start* initiative, for example.

Challenges and limitations of government interventions to reduce SIH

This document demonstrates that governments can, through comprehensive strategies aimed at combating SIH, adjust their economic, social and health policies so as to promote social equity. The comprehensive strategies outlined in this review are the product of many years of hard work. Despite the effort invested, these large-scale initiatives do not always produce the desired results. Even though they often promote health improvement for all social groups, they very often fail to reduce health disparities between groups. Sectoral or cross-sectoral interventions that focus more specifically on particular determinants of health can strengthen these global approaches because they have a more direct bearing on SIH. Interventions aimed primarily at promoting more egalitarian access to resources, such as interventions focused on income, work, and access to education and services, as proposed by Link and Phelan, are avenues worth exploring.[3]

Combating SIH can sometimes cause unwanted effects, such as when government interventions threaten to widen health gaps. In fact, foreign experiences demonstrate that it can be difficult to reach the most disadvantaged populations and that the implementation of universal strategies can, in some cases, inadvertently increase SIH by more successfully reaching advantaged groups, even if progress can be observed among more disadvantaged groups. It is obvious that the problem of social inequalities in health is vast and complex and that unequal power dynamics and exclusion, as well as certain policies and social norms and practices generate social and health disparities. Therefore, government intervention to reduce SIH is anything but simple, and necessarily takes place within a specific context and involves a set of interventions. There is no scientific consensus regarding how to effectively take action to reduce SIH. However, the need to take SIH into account when considering government intervention, at the very least to avoid worsening the situation, is acknowledged by experts. In addition, this review demonstrates that to reduce SIH, social policies must be strengthened both at the level of the general population (universal interventions) and at that of disadvantaged populations (targeted interventions), without stigmatizing the latter. Consequently, proportionately targeted interventions, or actions that target the general population, in conjunction with intervention that is modulated according to the social gradient of health, should be preferred and strengthened.

Québec's approach to social policies often reflects this perspective, favouring the association of universal interventions with proportionately targeted interventions. The Québec government could, like certain European countries, take a more specific and declarative stance in the fight against social inequalities in health by exploring a few policy avenues such as the promotion of a shared vision for reducing SIH that mobilizes all government sectors, the strengthening of achievements tied to social protection, to the fight against poverty and to action addressing the determinants of health, the establishment of a monitoring system and the participation of citizens in decision making. It can also enhance its policies based on the evidence brought to light by the numerous examples presented in this document.

Methodological approach

This document does not constitute a systematic and exhaustive review of the literature concerning the reduction of SIH. It is a narrative review of the grey and scientific literature, whose aim is to target examples of government interventions and measures on the basis of their impact on SIH. It is not a detailed analysis of public policies, but rather an overview of policy avenues for addressing this very broad issue. A number of reports produced by recognized experts and international organizations were consulted for the purpose of identifying the interventions presented in each section of this document. For the comprehensive approaches to combating SIH, the following dimensions were documented: responsibility (oversight, sector, level), scope of the intervention (universal or targeted measures), mechanisms for coordination, implementation and evaluation, intervention objectives related to SIH and factors that facilitate or impede the adoption and implementation of policies. For interventions focused on specific determinants, the foreign interventions that seemed the most innovative and able to inform reflection in Québec on how to combat SIH were selected, with choice being limited to interventions that did not have Québec equivalents and that were implemented in relatively comparable contexts. The adoption, implementation and monitoring of interventions was documented when data were available. The Québec interventions were identified through reference to the websites and publications of government departments and agencies and through consultation with certain key actors in the various sectors of intervention targeted in this document, so as to produce as complete a portrait as possible. The breadth of the topic covered imposed several limitations on this document; thus, it does not attempt to assess the interventions identified or to discuss the implementation of the Québec interventions listed. Moreover, since several of the strategies for combating SIH were implemented some years ago, the current political context of the countries discussed was not systematically taken into account. It should be noted that this review does not cover the range of tax policies, even though these may have an impact on social inequalities. This complex policy field could not be addressed within the context of this document. Finally, this paper was enriched by the comments of several experts working in the field of healthy public policy.

1 Social inequalities in health

The circumstances in which people are born, grow, study, work and live influence their health as much, if not more, than heredity or the health system available to them. The inequitable distribution of the social determinants of health between groups is the cause of unfair and significant differences in the health of people within a country or between countries.[4] Many factors, such as education, work, income, living environment, housing and access to services, determine an individual's state of health. Since these factors vary according to the socioeconomic status of individuals, they are referred to as **social determinants of health.**

These various determinants, which interact with each other and combine in various ways throughout the life course, can lead to significant differences in the health of individuals. The gaps, or unequal distribution of health status, linked to these determinants within a population are referred to as **social inequalities in health**. Because inequalities are avoidable, the WHO considers these gaps to be unfair (1). Unequal power dynamics and exclusion, as well as certain social policies, norms and practices engender these social and health disparities.

The primary causes of SIH are known as structural determinants, and include the socioeconomic context of a country, the values and public policies advanced by its government and the socioeconomic status of individuals. These determinants are positioned upstream of others, and can be thought of as the "causes of causes," since they influence other factors that have an impact on SIH.

These social differences in health are not observed solely between the richest individuals and the poorest. For most health indicators (e.g., the morbidity rate or life expectancy at birth), SIH follow a continuum based on income and education levels. In other words, individuals with a given socioeconomic status are less healthy than those positioned just above them on the social-income ladder. This upward gradation of health status based on socioeconomic status is called the **social health gradient**.

Reduction of SIH and intersectoral action

SIH are not inevitable phenomena. Various interventions, either comprehensive or focused on specific social determinants of health, can effectively help reduce SIH significantly. However, because SIH represent a complex social problem whose causes are multifactorial, solutions must involve several government sectors[5] and thus rely on **intersectoral action**.

Health in All Policies (HiAP) is one of the political strategies initiated by public health actors which relies on intersectoral action and makes health improvement a central government priority. The aim of this strategy, endorsed by the WHO, is to have health impacts taken into consideration in all policies from all sectors and for all levels of government to be involved in this process.[6]

Health Impact Assessment (HIA) is, in turn, a mechanism promoting intersectoral action that can help reduce SIH. HIA is defined as a set of procedures, methods and tools that makes it possible to anticipate the potential effects of a policy, program or project on the health of the population.[7] It is most often used prospectively, that is, prior to the adoption and implementation of a policy or project. HIA also analyzes the distribution of the potential effects of these interventions among different population groups and highlights the gaps and disparities between these groups. The WHO Commission on Social Determinants of Health recommends using a mechanism such as HIA to address inequalities. Equality and equity are central dimensions of HIA.

In addition, to better understand this social issue, it is necessary to supplement the population-level analyses developed by the public health sector with consideration of the broader **socio-political context**. A number of transformations within Western societies in recent decades have had a major impact on SIH, even though these are often difficult to quantify. To intervene efficiently, it seems necessary to take into account several contextual dimensions. Thus, SIH cannot be understood without considering the ideologies and values supported by governments and reflected in the social policies and social protection systems they establish.

This issue is also tied to the phenomenon of **exclusion** and to social inequalities in **access to resources.**[8] Exclusion is a multidimensional and dynamic process that determines whether individuals are integrated into society.[9] Barriers to social inclusion vary in nature and are often structural. They are reflective of social norms and, to some extent, of power relations within a society. These barriers may stem from material deprivation and poor access to resources, from geographical distance or from discrimination based on race, gender, sexual orientation, disability, etc. In all cases, exclusion raises the issues of social ties and solidarity, and also of power relations and empowerment, or the ability to influence the course of one's life and one's own health. In short, exclusion raises

the issue of all these contextual dimensions which must necessarily be taken into account for SIH to be understood and acted upon.

2 The scope of SIH in Québec

Data on the scope of SIH in Québec speak for themselves. In the most disadvantaged segment of the population (see the deprivation index charted below), 88% more individuals are daily smokers, 28% more are obese, 54% more are dissatisfied with their social life and 93% more people do not consider their health to be good, as compared with the most advantaged segment. Inequalities in Québec do not exist only between the extremes of the deprivation index, but rather follow a gradient.

There are also marked differences between socioeconomic groups in terms of life expectancy, as shown in Figure 1, and in terms of premature mortality. For example, in 2006, the gap in life expectancy between the most disadvantaged and most advantaged segments of the population was 8.1 years for men and 3.9 years for women.

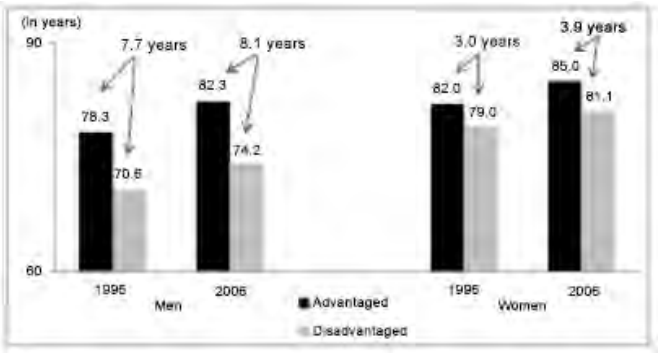
These results were reinforced by those of a study published in 2008 showing that social inequalities related to premature mortality increased in Québec between the periods of 1989-1993 and 1999-2003 at a rate that varies according to gender, cause of death and geographic area.[10]

Inequalities in life expectancy can be even greater when these are examined in terms of geographic location. Thus, in Nunavik, in the late 2000s, life expectancy lags behind the Québec average by 14 years and the gap has widened since the late 1980s (10).[11] Within a given region, such as Montreal, the gap in life expectancy at birth can exceed 10 years between populations such as those of the Hochelaga-Maisonneuve CLSC (74 years) and the Saint-Laurent CLSC (85 years), for example.[12]

A DEPRIVATION INDEX TO MEASURE SIH

A deprivation index was created by Québec researchers in the late 1990s to identify SIH and track changes over time across Québec (10).[13] [14] [15] [16] This index is used to classify the Québec population into five groups on a deprivation scale, ranging from the most disadvantaged to the most advantaged. One way to quantify SIH is to compare the values obtained for the most disadvantaged group with those of the most advantaged group.

Figure 1 Life expectancy at birth according to gender, for the most advantaged group and the most disadvantaged group, Québec, 1996 and 2006[17]



A study conducted in 2009, using the deprivation index to measure premature death (before age 75) across Canada, allowed for an initial comparison between SIH in Québec and in other regions in Canada (11). Thus, in 2001, differences in premature mortality between the extreme ends of the deprivation index were greater in Canada, as a whole, than in Québec. Across Canada, the greatest disparities in premature mortality are found in the Prairies and in British Columbia, while in Ontario the gap is smaller than in Québec.

Another study carried out by the Canadian Institute for Health Information[18] shows that, in general, for most of the indicators studied, the health gap between socioeconomic groups in both of the urban regions in Québec included in the study, Québec and Montreal, is smaller than the average for all the Canadian urban areas studied. This applies, in particular, to the Montreal region where the inequalities observed for each of the 21 indicators analyzed were consistently smaller than average.

TROUBLING GAPS

Québec's Aboriginal populations and SIH

Despite significant improvement in recent decades, it is clear that a troubling and, in some cases, alarming gap continues to exist between the health status of Aboriginal peoples and that of the non-Aboriginal population.[19] [20] The largest differences are generally observed in traumatic injuries, chronic diseases and certain communicable diseases. Compared with the Canadian population, First Nations people in Québec have a life expectancy that is 6 to 7 years shorter; a diabetes rate that is two to three times higher; an obesity rate that is also two to three times higher; and a likelihood of experiencing, beginning in childhood, poverty, abuse and out-of-home placement

that is 3 to 5 times higher.[21] The socioeconomic status of First Nations people is also a critical issue given that one in four adults is receiving employment insurance, about half of adults did not graduate from high school, two out of three women have an income below $10,000 and almost half of families (44%) are single-parent families (19).

Most of the conditions that promote good health are severely lacking for a large part of the Aboriginal population in Québec. Among the determinants that have a major influence on Aboriginal health, the most noteworthy are historical and colonial background.[22] the current legal and judicial context, discrimination and social exclusion, poor access to education and to appropriate health services, poverty, the deterioration of the natural environment, the poor quality of the built environment (e.g., the quality of housing, access to water and sanitation) and lifestyle.[23] Aboriginal people who face inequalities related to the social determinants of health must not only cope with more health problems, but also, quite often, with more limited access to resources for addressing these problems. The need to recognize and take into account these social disparities in health is urgent, especially since Aboriginal people are the most rapidly growing demographic group in the country: more than 65% of this population is under the age of 25 (23).

The implementation of measures targeting inequalities in these populations requires the adaptation of such measures to local conditions, such as the language of use and geographic isolation, and the recognition of historical and cultural contexts.

The health of Québec women, income and employment

There are significant disparities between men and women in Québec. Although Québec women have a longer life expectancy at birth than Québec men, the gap is much smaller for healthy life expectancy.[24] Women suffer more from severe functional health problems, disabilities or health problems that limit their activities.[25] Women are more likely (23.2%) than men (16.6%) to report a high level of psychological distress and are also more likely to suffer from musculoskeletal disorders and mental health problems associated with their work (25)

With regard to employment income, women have lower incomes than men, even when they work full time[26] or have completed university studies.[27] In 2011, 59.8% of minimum wage workers were women, although women only represent 47.3% of the working population (27). In 2006, 77.9% of single-parent families were headed by a woman, and nearly a quarter of single-parent families are considered low income after tax (26).

While these disparities are significant in themselves, it should be noted that income and employment insecurity among women has a direct impact on families and children that can lead to poverty and exclusion.

3 Interventions to reduce SIH

“Inequity is systematic, produced by social norms, policies, and practices that tolerate or actually promote unfair distribution of and access to power, wealth, and other necessary social resources.” (4)

Governments have developed different approaches to combating SIH. Some countries have, for example, adopted a systematic and comprehensive policy to reduce SIH, while other governments have instead developed a national public health policy explicitly aimed at reducing SIH, or at addressing the social determinants of health upstream. In addition to these global approaches, a number of sectoral or intersectoral interventions focused on health determinants are proving significantly helpful in combating SIH.

The following sections firstly present comprehensive approaches to combating SIH taken by various countries, then the intervention context in Québec and, thirdly, interventions that more specifically target determinants, in Québec and abroad. Targeted interventions in the following sections will be discussed: Early childhood and education, Employment, income and social solidarity, Environment and land use planning, Lifestyle and Health and health services.

Although experts recognize the need to take SIH into account when planning government intervention, so as not to worsen such inequalities, it should be noted that there is no scientific consensus regarding how to effectively take action to reduce SIH. However, this review demonstrates that governments can, through comprehensive strategies aimed at combating SIH, adjust their economic, social and health policies so as to promote social equity. Despite the effort invested, these large-scale initiatives do not always produce the desired results. Even though they often promote health improvement for all social groups, they very often fail to reduce health disparities between groups. Sectoral or cross-sectoral interventions that focus more specifically on particular determinants of health can strengthen these global approaches because they have a more direct bearing on SIH, particularly interventions

aimed primarily at promoting more egalitarian access to resources, such as interventions focused on income, work, and access to education and services, as proposed by Link and Phelan (8), are avenues to be promoted.

Thus, this review demonstrates that, to reduce gaps between groups, social policies should be strengthened in a manner that strikes a balance between universal measures that affect the entire population and measures that proportionately target disadvantaged groups, while being careful not to stigmatize the latter. This overview is intended to stimulate reflection on this highly complex issue.

4 A Comprehensive government approaches observed elsewhere in the world

Several countries, each in accordance with its own political context, have adopted a broad approach that encompasses several sectors of intervention. The United Kingdom, Finland, Sweden, Norway, Australia and New Zealand are recognized for their experience in this area. This section examines interventions aimed at reducing SIH in the above countries that could prove highly instructive for Québec, despite its status as a provincial government acting within a federal context.

United Kingdom[1]

The United Kingdom was the first country to adopt a comprehensive policy specifically aimed at reducing SIH. To date, few countries have implemented as systematic an approach.[28] The British strategy for reducing inequalities highlights the importance of developing a plan for government action in concert with the various government departments and with local organizations. It should be noted that this strategy benefited from the stability of the Labour government, which spearheaded the project and which held power for 13 years (28). The coming years will reveal how this strategy, which has been in place for more than a decade, will be upheld by the coalition government (Conservative and Liberal Democrat) elected in 2010.

[1] We consider the UK in its entirety even though jurisdiction over health has been devolved to the governments of England, Scotland, Wales and Northern Ireland since the late 1990s. The reason for this is that intervention on SIH involves all sectors and especially fiscal policies which are still largely determined by the central United Kingdom government. See Chapter 4 of the following: Raphael, Dennis. 2012. Tackling Health Inequalities. Lessons from International Experiences, Canadian Scholars' Press Inc, Toronto.

Over the last decade, the central government has played a predominant role in coordinating health policies and other policies associated with combating SIH or with health promotion. To this end, a special unit of the Department of Health provides expertise and coordinates actions that target SIH from an intergovernmental standpoint. This unit liaises with all government agencies and ensures that SIH are integral to the concerns and efforts of other departments.[29]

Since 2004, programs and policies have been subject to the HIA process. As regards the health system, regional or local offices must also submit to an assessment of their equitability (an *equity audit*) and rectify problems if necessary.[30] The National Institute for Health and Clinical Excellence (NICE) is responsible for evaluating interventions.

In 2011, the current coalition government published its national public health strategy, *Healthy Lives, Healthy People*[31] which emphasizes continued action to combat SIH. This strategy calls for the devolution of new responsibilities for health to the local level, giving directors of public health more freedom to act independently to reduce SIH in their community, in partnership with all public, private and community actors. It also announces a major reorganization of the health system, with a greater focus on emergency preparedness, became effective in April 2013.

Historical context of the fight against SIH in the United Kingdom

The history of the struggle against SIH in England is particularly useful for shedding light on the context of international intervention in this area because it has served as the inspiration for many countries. Concern about SIH emerged in 1980 with the appearance of the ***Black Report*** which reported increasing social inequalities in health among workers. However, it was not until 1998 and the return of the Labour government that inequalities were placed on the government's agenda, by the important *Acheson Report*,[32] which charted the distribution of SIH among different population groups and throughout the life course. This report recommends acting directly on the social determinants of health by adopting policies aimed at reducing poverty and income inequality. The government launched its strategy the following year in the white paper *Saving Lives: Our Healthier Nation*[33] along with its initial action plan, set out in *Reducing Health Inequalities: An Action Report*.[34] Beginning in 2001, quantifiable national targets linked to SIH were set, such as a reduction in the infant mortality gap between social categories and a

reduction in the chronic disease mortality rate in disadvantaged areas. In 2003, the government involved twelve government departments and agencies in its cross-sectoral action plan to combat inequalities, set forth in *Tackling Health Inequalities: Programme for Action*.[35] Despite the scope of this SIH reduction strategy, a *National Audit Report*[36] found, in 2010, that apart from some gains in life expectancy recorded in problem areas, existing gaps had, in fact, widened within the overall population. At the request of the Secretary of State for Health who wished to remedy this situation, Sir Michael Marmot published, in the same year, a report entitled *Fair Society, Healthy Lives*[37] aimed at identifying the best strategies for reducing SIH that address the determinants of health. This report recommends adopting universal interventions, but proportionately targeting these to reduce gaps between all groups.

Finland

Finland was one of the first countries to develop a national policy on population health explicitly aimed at reducing health inequalities through its strategy *Health for All by the Year 2000 – The Finnish National Strategy,*[38] adopted in 1986. Despite some progress toward achieving the targets of this initial strategy, persistent and even widening inequalities contributed to Finland's adoption, in 2001, of the *Health 2015 Public Health Programme*[39] whose aims include a 20 percent reduction, by 2015, in the mortality gap between men and women and between groups with varying levels of education and professional status. Within the context of this program, the Finnish government launched the *National Action Plan to Reduce Health Inequalities 2008-2011*.[40] The interventions included in this action plan are focused on three priority areas: social policy measures, the encouragement of healthy behaviours and improved access to social and health services.

In addition, Finland has long recognized that the policies of sectors other than that of health have a bearing on the achievement of health goals. Their "health in all policies" approach fostered the emergence of a series of interventions in different sectors aimed at improving health and promoting social inclusion. In addition, in 2010, the Ministry of Social Affairs and Health launched a new strategy, *Socially Sustainable Finland 2020. Strategy for social and health policy*[41] aimed at reducing persistent inequalities in health and welfare. Inclusive of several sectors, this strategy aims, among other things, to extend the active working life of individuals by three years, by 2020.

The Finnish government has assigned responsibility for coordinating and monitoring the implementation of interventions targeting SIH to the Ministry of Social Affairs and Health. The intersectoral Advisory Board for Public Health, chaired by the Permanent Secretary of this ministry, is, for its part, in charge of the action plan's steering committee. Under this plan, many actors are expected to play a role in reducing SIH, including several ministries, federations of municipalities and local governments, non-governmental organizations and civil society partners, as well as the business community.

Sweden

Sweden, a Scandinavian country with a social democratic tradition, has for many years had a solid reputation for developing and implementing health-promoting and equitable public policies. The social protection system, within which the principle of universality is applied to all policies, can be viewed as an approach to reducing social inequalities.

Adopted in 2003, the *Swedish National Public Health Policy*[42] aims to improve the health of the population and reduce inequalities by focusing on the determinants of health and adhering to the concept of *good health on equal terms*. In 2007, following the election of a new government, this policy was renewed, with some adjustments that place greater emphasis on individual responsibility. Taking a broad view of the life course, this policy focuses on improving the early living conditions of children and youth by promoting initiatives that support parents and strengthen their abilities. For example, it advanced the *National Strategy for Parental Support*[43] implemented in 2009-2010, which aims to provide support for all parents of children aged between 0 and 18 years old. Beginning in 2007, other programs or interventions were also put in place to target social exclusion, a problem which is considered a threat to public health.

From the Swedish perspective, the collaboration of all sectors is necessary if the objectives linked to the struggle against SIH are to be achieved. Therefore, the public health research and practice communities work in partnership with decision-making bodies (national, regional and municipal) in an effort to promote health in all policies. The Swedish National Institute of Public Health (SNIPH)[44] is the government agency responsible for monitoring the implementation and evaluation of the national policy. This agency works cooperatively with the various sectors, as well as at several levels of governance.

Norway

Like its Swedish neighbour, Norway has in recent years seen the overall health of its population improve.[45] This country ranks first according to the Human Development Index.[46] However, as in the case of Sweden, SIH have not followed the expected trend and have grown rather than shrunk. In this country, the maintenance of a universal social support system, more than any other measure, is seen as an effective way to combat SIH. Norway is also distinguished by its confirmed strategy of implementing structural measures to promote health. With a strong tradition in this area, the Norwegian government is guided, in particular, by the results obtained with respect to the prevalence of tobacco use, and chooses to focus on targeted interventions aimed at providing an environment that encourages healthy lifestyles.

It was through the process of revitalizing its universal and structural measures that Norway undertook to address SIH. The Norwegian Public Health Act[47] makes reducing inequalities through action on the determinants of health a core concern of public health at the national, regional and local levels.

The national strategy is aimed at pursuing the work outlined in a white paper published in 2003 and in the action plan for addressing the health gradient entitled *The Challenge of the Gradient*[48] published in 2005. The *National Strategy to Reduce Social Inequalities in Health*[49] presented and approved in 2007 tackles the problem by seeking to promote equity as "good public health policy."

As in Sweden, in Norway the government has stressed the need for intersectoral cooperation to counter SIH. The national strategy is therefore aligned with the national health policy, the *National Health Plan for Norway 2007-2010*,[50] and also with the interventions included in the employment, social protection and inclusion program, *Employment, welfare and inclusion 2006-2007*,[51] with the action plan for combating poverty, the *Action Plan Against Poverty 2008*[52] and with the policy on intervention in education, outlined in *Early intervention for lifelong learning 2006-2007*.[53] Thus, although overall responsibility for the strategy, including the role of monitoring and evaluation, rests with the Ministry of Health and Care Services, it requires the involvement of all sectors to be successful.

Australia

Australia has been concerned with improving population health and reducing SIH for over 25 years. The creation in 1973 of the *Community Health Program (CHP)* as a supplement to universal health insurance, with the aim of providing everyone with access to basic health care, helped put the fight against inequality on the political agenda.[54] Over 700 projects stem from this initiative, which provided the foundation for subsequent actions targeting inequalities.

Over the past decade, the Australian federal government has supported the *Equity-Focused Health Impact Assessment Framework*,[55] outlined in this 2004 publication, intended to encourage the development of health impact assessments focused on equity and the funding of research on inequalities, such as that carried out under the *Australian Health Inequities Program*.[56] Special attention was also focused on the health of targeted disadvantaged groups, such as Aboriginal peoples, with the implementation in 2008 of *Closing the Gap: The Indigenous Reform Agenda*.[57] This integrated national strategy, involving all levels of government, is aimed at improving the living conditions of Aboriginal peoples and at reducing the gap between their life expectancy and that of the rest of the population.

The Australian government also launched an innovative strategy in 2010, outlined in *Taking Preventative Action – A Response to Australia: The Healthiest Country by 2020*,[58] which is centered around the concept of prevention and is aimed, in particular, at encouraging individuals to change their behaviour and adopt healthy lifestyles. The reduction of socioeconomic and geographical inequalities in health is central to this strategy. In 2010, the federal government created the Australian National Preventive Health Agency,[59] a national body responsible for supporting strategic partnerships, between all sectors and at all levels of government, for promoting health and reducing inequalities.

Some Australian states have also attempted to address the issue of SIH, as did the State of New South Wales in 2004 with the adoption of the policy *In All Fairness – Increasing equity in health across NSW*.[60] For its part, the State of South Australia has, since 2007, advanced a Health in All Policies strategy, leading to central government processes aimed at improving health and reducing inequalities.[61]

New Zealand

Since the early 2000s, New Zealand has taken a comprehensive approach to reducing SIH. The struggle against SIH in New Zealand is characterized specifically by the persistence of a significant health gap between Maori and non-Maori peoples, an issue that has determined the focus of many government interventions. Another distinctive feature of the New Zealand approach is that the development and implementation of policies is carried out in conjunction with research on the determinants of health and the development of tools for monitoring inequalities. Finally, the use of health impact assessment (HIA) and the intersectoral approach adopted by this country make it an example worthy of interest.

In 2002, the Ministry of Health launched the *Reducing Inequalities in Health*[62] strategy focused on intervention targeting four main concerns: social, cultural, economic and historical factors at the structural level; intermediate material, behavioural and psychosocial factors; health services; and finally the impact of SIH at the national, regional and local levels.

Over the last decade, in accordance with the established guidelines, several equity-promoting policies (*Working for Families*,[63] *Whanau Ora*[64]) have been implemented and many intersectoral initiatives have emerged across the country. With respect to equity for example, the Health Equity Assessment Tool (HEAT),[65] was developed by the Ministry of Health in partnership with the Wellington School of Medicine, to better integrate the issue of SIH into health policies, programs and services, as well as into the policies of other sectors such as transportation or family. Moreover, since 2007, health impact assessments (HIA) have been strongly encouraged by the new Public Health Bill,[66] although they are not mandatory.

KEY POINTS TO NOTE CONCERNING COMPREHENSIVE APPROACHES TO COMBATING SIH

The above overview of foreign experiences reveals that the implementation of comprehensive approaches to combating SIH has most often been the work of governments headed by centrist, labour or social-democratic parties benefiting from political stability. Some of the countries examined were easily mobilized around the issue of SIH, which was aligned with the social values and social protection systems already promoted by these governments.

All of the countries discussed recognize the need the work intersectorally to address SIH. The global approaches they have adopted generally fall under the responsibility of their departments of health, who, in almost all cases, have an expanded mandate that includes social services and/or social affairs. The United Kingdom, Finland and New Zealand have established government bodies to oversee intersectoral coordination or introduced advisory mechanisms to ensure the implementation of their policies. The United Kingdom, Sweden and Australia have assigned expert organizations responsibility for knowledge transfer, as well as for the monitoring and evaluation of interventions. Several of these countries also make use of HIA. In addition, it appears that regional and local authorities often play a key role in implementing global approaches, since they are, in many cases, introduced at these levels of governance.

Thus, this overview highlights some of the conditions that favour implementation of a comprehensive approach to reducing SIH, including political will and stability, the promotion of justice and equity as social values, and intersectoral governance that mobilizes the various sectors and levels of government. However, it also reveals that, on the one hand, the impact of the interventions implemented is often not evaluated and, on the other hand, that the results obtained so far have not always been those expected. Foreign experiences demonstrate, ultimately, that it can be difficult to reach the most disadvantaged populations using only a universal strategy. This type of intervention, which targets the entire population, can increase SIH by more successfully reaching advantaged groups. The challenge is to find a balance between universal measures that affect the entire population and measures that proportionately target disadvantaged groups without stigmatizing them.

5 SIH in the Québec context

Québec is recognized for having advanced a model of social protection consistent with those that are the focus of discussion in Europe,[67] which distinguishes it within the North American context. However, unlike the countries previously discussed, Québec has not adopted public policies which specifically or globally target the reduction of SIH. Nor has it established a formal system for monitoring SIH and, therefore, has not set specific targets for the reduction of SIH. The Québec government has mainly implemented a series of policies that, although not introduced specifically to combat SIH, may have a real effect on these by targeting one or more determinants of health. The Québec government has also established strategies for supporting intersectoral action that can serve as levers for action in the struggle against SIH.

Intersectoral action

To ensure coordination of the efforts of the various sectors in matters relating to health, welfare and poverty reduction, the Québec government has introduced in its Public Health Act (2001)[68] and in An Act to Combat Poverty and Social Exclusion (2002),[69] two articles with an innovative impact: Section 54 and Section 19, respectively.

Section 54 of the Public Health Act[70] calls on the Minister of Health and Social Services to give "other ministers any advice he or she considers advisable for health promotion and the adoption of policies capable of fostering the enhancement of the health and welfare of the population." This section, which also stipulates that the Minister of Health "shall be consulted in relation to the development of the measures provided for in an Act or regulation that could have significant impact on the health of the population" has led to the development and implementation of an intragovernmental health impact assessment (HIA) mechanism, one of whose goals is to help reduce SIH.

The Comités ministériels permanents du Conseil exécutif et leurs secrétariats [71] [standing ministerial committees of the executive council and their secretariats], which are responsible for ensuring greater coherence and better coordination of government activity, also play a role in the implementation of Section 54 and of the HIA process. The main committee active in this area is the committee for social, educational and cultural development, now called the "comité de la solidarité" [solidarity committee] under the current government.

Following a long process of citizen and community mobilization led by the Collectif pour un Québec sans pauvreté [collective for a poverty-free Québec], the National Assembly adopted, in 2002, the Act to Combat Poverty and Social Exclusion[72] (Law 112) and the *National Strategy to Combat Poverty and Social Exclusion*,[73] The strategy for implementing this law was outlined in 2004 in the *National Strategy to Combat Poverty and Social Exclusion: The Will to Act – The Strength to Succeed*, intended to "progressively transform Québec, over a ten-year period, into one of the industrialized societies with the least poverty." This national strategy calls for the mobilization of all activity sectors.

Section 19 of the Act to Combat Poverty and Social Exclusion,[74] for its part, provides for the adoption of policies that improve the economic and social conditions of individuals and families experiencing poverty and social exclusion. In addition, Section 20 of the same act stipulates that ministers who believe their bills or regulations could have direct and significant impacts in this area must give an account of those impacts when presenting their projects to the government.

The *Government Sustainable Development Strategy 2008-2013*,[75] which integrates social, economic and environmental concerns, allows complex issues to be tackled from different angles and can also function as a lever for promoting intersectoral action to reduce SIH. This framework defines a set of strategic guidelines and objectives, including an explicit directive to "prevent and reduce social and economic inequality." This strategy is aimed at coordinating government efforts to develop and implement action plans for sustainable development in all sectors.

As with Section 54, the standing ministerial committees of the executive council and their secretariats play a role in the implementation of the *Sustainable Development Strategy*. They are ultimately responsible for advising the council of ministers as to the compliance of projects submitted by departments and agencies with the government's policy on sustainable development. Another pre-existing mechanism, the Comité interministériel du développement durable (CIDD),[76] [interdepartmental committee on sustainable development] facilitates the implementation of this government strategy.

Initiatives advanced by public health authorities

Some initiatives advanced by the public health sector are developed alongside health care and services programs, which help fight against SIH by providing Quebecers with universal coverage, offering free health care and prescription drugs at a reduced cost. These initiatives rely on intervention at various levels, including that of the central government and the regional and local levels. Section 8 of the Québec Public Health Act, adopted in 2001, states that "The Minister shall, in developing the components of the program that relate to prevention and promotion, focus, insofar as possible, on the most effective actions as regards health determinants, more particularly actions capable of having an influence on health and welfare inequalities in the population and actions capable of decreasing the risk factors affecting, in particular, the most vulnerable groups of the population". A few years later, the *Québec Public Health Program 2003-2012*[77] updated in 2008, identified the reduction of health inequalities as one of the four main challenges associated with its planned activities. The interventions described in this program target the health of the entire population, but it should be noted that several interventions focus on the most vulnerable groups and that the program clearly affirms the importance of promoting public policies likely to reduce health inequalities. The program also aims to improve access to health and social services for the most disadvantaged persons. Community development is also broadly supported by this program as one of the action strategies of public health actors, to be carried out, in particular, through agencies, health and social service centres (Centres de santé et de services sociaux or CSSSs) and the department of health.

Some point out that it has proved a struggle to translate these good intentions into concrete goals or firm targets aimed at reducing SIH.[78] However, these intentions attest to the awareness of this issue in Québec. For example, the publication of the first report on social inequalities in health by the DSP Montreal Centre [Montreal public health branch] in 1998 led to the creation of the Observatoire montréalais des inégalités sociales et de la santé [Montreal observatory of social inequalities and health]. The same year, a ministerial committee for the reduction of health inequalities linked to poverty was created and, in 2002, it published the report *La réduction des inégalités liées à la pauvreté en matière de santé et de bien-être : Orienter et soutenir l'action!*[79] [reducing inequalities in health and well-being linked to poverty: guiding and supporting action!] In addition, the Forum sur le développement social [forum on social development], held in 1998, led to the establishment of many levers for social development such as regional agreements, the naming of national and regional public health respondents for community development, the creation of the journal *Développement social*,[80] the creation of the Réseau québécois de développement social [Québec network for social development], etc. The public health monitoring sector also greatly contributed to defining the profile of SIH in Québec, particularly in the early 2000s, with the development of the deprivation index.

More recently, three Québec directors of public health published reports entirely devoted to the issue of SIH in their respective regions: these include the second report[81] of the Montreal health branch in 2011, the report of the Mauricie and Centre-du-Québec region (2012[82]) and that of the National Capital Region in 2013.[83]

Canadian context and federal government policies

Whether initiating policies and programs in sectors that can positively influence the determinants of health or intervening directly in the health sector, the Québec government is acting within the context of the Canadian federal government and must adjust to the direction and initiatives taken at the federal level. Some initiatives are carried out in partnership with the federal government or are subsidized by the latter.

The Canadian federal government has not advanced a strategy for reducing SIH, although some recent government productions, such as the first annual *Report of the Chief Public Health Officer of Canada*,[84] published in 2008, or the reports of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology,[85] acknowledge the importance of tackling this growing problem in the country.One of the federal government's major initiatives is the Canada Health Act,[86] which governs Medicare by dictating the principles with which provincial health systems must comply to obtain federal transfers. Its aim is to ensure universal, free access to health services.

In the context of the Canadian federation, the federal government can intervene in various sectors and help reduce inequalities, mainly by ensuring a minimum income and through measures related to housing. Given these parameters, the main federal monetary transfers paid directly to individuals go to the unemployed, the elderly and families, through programs such as employment insurance benefits,[87] old age security,[88] the guaranteed income supplement[89] and various transfers to families. With regard to housing, the Canada Mortgage and Housing Corporation (CMHC) plays a major role both in relation to access to property and to social housing.

Federal transfer payments are also made to the Québec government for matters relating to health, education and social programs.

6 Government policies focused on specific health determinants in Québec and elsewhere in the world

Implemented alongside these comprehensive approaches, a number of sectoral or intersectoral interventions focused on specific health determinants can contribute to combating SIH, without necessarily targeting them in advance.

6.1 Early childhood and education

Why take action?

Studies on social determinants of health generally ascribe great importance to interventions that focus on early childhood development and youth education. Academic success contributes to social and professional integration, and educational level is a determinant of health independent of socioeconomic status.[90] Early childhood has gained considerable attention due to recent studies that clearly demonstrate just how sensitive to external stimuli brain development is during the first few years of life, and how lasting these effects are.[91] Not only do difficult situations experienced in early childhood have an immediate impact on a child's health and chances for success, but the SIH that begin at that age continue to grow over time and persist into adulthood, and this is directly linked to shorter life expectancy.[92] [93]

Family support, childcare services, and perinatal services

QUÉBEC INTERVENTIONS

To provide assistance to families, Québec has adopted the *Québec Parental Insurance Plan*[94] for workers who take maternity leave, paternity leave, parental leave or adoption leave. The *QPP*[95] launched the *Child Assistance Measure*,[96] which has replaced family allowances and benefits, and the *Supplement for Handicapped Children*.[97]

With regard to childcare services, parents have access to a limited number of places in daycare centres at a cost of $7 a day under the government's *Reduced-Contribution Program*.[98] Public daycare centres must apply *Québec's educational program for childcare services*.[99] Moreover, Bill 23,[100] which was adopted in June 2013, grants access to early childhood educational services to all 5-year-olds (4 years of age for children from disadvantaged backgrounds).

Pregnant women and mothers living in vulnerable situations (poverty, young age, or parents with low levels of education) are eligible to receive *Services intégrés en périnatalité et petite enfance (SIPPE)*[101] [integrated perinatal and early childhood services], from the beginning of a pregnancy until the child reaches age five. An assistance is offered to families with the aim of supporting parents and creating an environment that is conducive to optimal child development.

With regard to work-family balance, the ministère de la Famille [department for families] implemented the *Programme de soutien financier aux milieux de travail en matière de conciliation travail-famille*[102] [financial support program for workplaces - balancing work and family] from which stems the *norme Conciliation travail-famille*[103] [work-family balance standard] from the Bureau de normalisation du Québec [Québec standards bureau] to encourage workplaces to establish and implement management practices and measures to reconcile work and family.

Promising examples from abroad

- The United Kingdom's early childhood development program entitled *Sure Start*[104]

This program aims to increase the chances of success of children both in school and once they reach adulthood, thus reducing poverty and its intergenerational transmission. It works to bring together childcare, early education, health promotion and family support services in a coordinated way. In addition to providing daycare services, the network of *Sure Start Children's Centres* also offers employment reintegration services for parents.[105] These centres are not limited to the most disadvantaged areas and are controlled by local authorities; however, childcare and professional assistance services vary according to the levels of deprivation within sectors. A longitudinal evaluation of the program showed clear benefits such as improved infant health and better screening. It concludes that the most effective *Sure Start* programs were those that favoured the integration of complementary services.[106]

- The Swedish family policy[107]

In Sweden, parental leaves granted to new parents (up to 16 months, 13 of which are with full pay) help ensure favourable material conditions for families and also

contribute to strengthening the child-parent bond.[108] The Swedish government offers nearly universal access to high-quality daycare and early education services provided by specialized teachers holding university degrees. Not only does this system help reduce inequalities in child development, it also facilitates women's participation in the labour market, thereby decreasing the rate of poverty for single mothers, for whom the work-family balance is a challenge.

Academic success and learning support services

QUÉBEC INTERVENTIONS

In order to improve student retention and academic success, the Ministère de l'Éducation, des Loisirs et des Sports[109] (MELS) [department of education, recreation and sports] adopted the I care about school![110] strategy. This strategy comprises several interventions such as reducing the number of students per class in elementary school, offering homework assistance, providing individualized support for students who have repeated a year, promoting vocational training in high school, and reinforcing the New Approaches, New Solutions,[111] intervention strategy, whose evaluation report[112] asserts that, although it achieved no measurable changes in academic achievement levels among disadvantaged students, in an improved form, this program could become a promising tool.

The Healthy Schools[113] program, under the joint responsibility of the Ministère de la Santé et des Services sociaux (MSSS) [department of health and social services] and the MELS, aims to implement effective prevention and promotion practices in schools, in a comprehensive and concerted way, so as to promote the educational success, health and well-being of young people.

Moreover, the Québec government offers financial aid to students[114] in the form of loans and bursaries, administered by the MELS,[115] in an effort to promote access to education. This program comprises various measures such as the Work/Study Program[116] to help reconcile work with studies.

Promising examples from abroad

- Ireland's School Support Programme entitled *Delivering Equality of Opportunity in Schools (2005-2010)*.[117]

This action plan focuses on addressing and prioritizing the educational needs of children and young people from disadvantaged communities, from pre-school through second-level education. It aims to provide children from disadvantaged communities with a positive learning environment through a set of integrated interventions including, for example, a lower pupil/teacher ratio, literacy and numeracy programs, support for school libraries, support for teaching staff and school principals (sabbatical leaves for continuing education, lower threshold for numbers of pupils and teachers), enhanced career counselling in high school, more curriculum choices, continuing education for school staff, strengthening of partnerships, and a services offer integrated with other agencies offering services for the same target clientele. A 2011 analysis report[118] of the first three years of the program found significant improvements (literacy, numeracy, attendance) despite negative economic conditions.

- Norway's academic success strategy entitled *Early Intervention for Lifelong Learning*[119]

The Norwegian government's white paper is an example of an early childhood development intervention that continues beyond the first few years of life. Implemented in 2006, this strategy introduces various measures for promoting academic success, including early language stimulation (starting in daycare), ongoing follow-up support throughout the school year as needed, homework assistance, individual assessment, and adapted education as soon as a problem is detected. This strategy also proposes increased physical activity, provision of fruit and greens at school, counselling services in high school to reduce the dropout rate, training programs for teachers and other staff, and adult education initiatives. The originality of the Norwegian plan is its focus on lifelong learning and the importance it attributes to language development.

KEY POINTS TO NOTE ON EARLY CHILDHOOD AND EDUCATION

Québec offers a variety of programs to support families during the perinatal period through infancy: these programs include income support, parental leaves, access to quality childcare services and early childhood education, as well as an integrated program for vulnerable families. However, the benefits for child development would be increased if the network of early childhood centres was available universally (it is currently limited). It should also be noted that the parental leave plan lacks a high degree of flexibility in comparison to the examples from Scandinavian countries. With respect to academic support, programs that target academic success have been in place for years in Québec and some progress has been achieved, but this remains a significant issue, particularly among boys in disadvantaged environments and among students from recently immigrated families.[120] The examples from other countries point to promising avenues tied to the flexibility and duration of parental leaves, the generous sums of allowances and benefits offered, the integration of services and increasing focus on at-risk groups, the ongoing support provided to groups or individuals at risk of academic difficulty, and finally, the support offered to teachers and school principals.

6.2 Employment, income and social solidarity

Why take action?

Employment and income are major determinants of SIH. Unemployment and job insecurity have been clearly shown to have adverse effects on health. All government interventions aimed at reducing SIH must prioritize employment, since it is the main driver for improving living standards. Not only does employment represent one of the primary means of meeting basic needs such as housing and food, it also fulfils key social needs in societies where it is the norm, namely the need for social integration and a sense of belonging and usefulness, which are also recognized as determinants of health and well-being. However, employment in itself is not always a guarantee of better health. In fact, employment must be well remunerated and secure for any real health improvement to be achieved. That said, over the last few years in Québec and in many other Western societies, there has been a rise in temporary and non-standard work, and the number of workers living in poverty continues to grow as well. In addition, the physical and psychosocial constraints linked to employment—such as physical work conditions, minimal control over tasks, inadequate support from peers or supervisors, job insecurity or insufficient income—can be pathogenic. Therefore, policies aimed at ensuring healthy work conditions and at helping people enter the labour market have the potential to reduce SIH by improving both material and psychosocial factors. Most developed countries have also implemented minimum income support policies to assist individuals incapable of supporting themselves.

Social transfers and adequate minimum income

QUÉBEC INTERVENTIONS

The Québec population has access to a *Social Assistance Program*[121] and a *Social Solidarity Program*[122] both under the responsibility of the Ministère de l'Emploi et de la Solidarité sociale (MESS) [department of employment and social solidarity] and intended to provide last resort financial assistance to designed to help ensure a minimum level of income and to grant financial assistance to persons who may or may not have a severely limited capacity for employment. The *Youth Alternative Program*[123] specifically targets young people under age 25 and comprises an intervention plan for entering the job market. As for the *Québec Pension Plan*,[124] this is a compulsory public insurance plan designed to provide persons who work in Québec (or have worked in Québec) and their families with basic financial protection in the event of retirement, death or disability.

Employment assistance and support

QUÉBEC INTERVENTIONS

The government has introduced a number of measures to facilitate access to the labour market and to support workers. Emploi-Québec is responsible for implementing many of the employment assistance measures such as the Emploi-Québec is responsible for implementing many of the employment assistance measures, such as the *Stratégie de mobilisation tous pour l'emploi*[125b] [mobilization strategy for employment for all], *Employment Pact*,[126] employment assistance allowances,[127] wage subsidies[128] and skills training.[129] Revenu-Québec is responsible for the *Work Premium*,[130] a refundable tax credit intended for low- or middle-income workers.

To help promote the innovative business projects of young people from underprivileged backgrounds, the Ministère des Finances et de l'Économie (MFE) [department of finance and the economy] launched the *Stratégie québécoise de l'entreprenariat*[131] [Québec entrepreneurship strategy]. The MESS is responsible for overseeing the *Income Support Program for Older Workers*[132] which provides monthly financial assistance to older workers who were dismissed or laid off because

of the economic situation. Finally, the *Employment Integration Program for Immigrants and Visible Minorities (PRIIME)*[133] is the result of a partnership between Emploi-Québec, the Ministère de l'Immigration et des Communautés culturelles (MICC) [department of immigration and cultural communities] and Investissement Québec.

Promising examples from abroad

- Minimum income support measures in Europe

Many European countries provide monthly cash benefits, as do Canada and Québec, under the provisions of a minimum income guarantee (or subsistence allowance) to individuals and families.[134] However, this is supplemented in Germany and Sweden by the reimbursement of reasonable and actual expenses for housing and heating (Sweden also provides reimbursement of membership dues for a trade union and/or an unemployment insurance fund), and the United Kingdom provides supplementary allowances for housing and local taxes. In these three countries, financial assistance is payable to all individuals whose income is too low to cover the fixed costs of living. One study shows that social policies that lean towards universal coverage and that deliver more generous benefits are linked to a longer life expectancy,[135] and it has been demonstrated that the more generous the earnings-related parental leave benefits, the lower the infant mortality rate.[136]

- Activation policies

As in Québec, a number of countries have also set up activation policies—that is, a set of programs and measures integrating financial aid and job search assistance for unemployed individuals—for example, Norway's *Work, Welfare and Inclusion*[137] and New Zealand's *Better work – Working better*[138] strategies. These approaches not only offer financial support, they also propose follow ups, skills development and on-the-job training. Penalties may be imposed, in the event participants fail to attend scheduled meetings or refuse to accept available positions. While some of these programs have succeeded in reducing psychological distress, depression and the risk of suicide, others have not shown positive effects on health.[139] These programs raise health issues connected with the low quality of the jobs (insecure, low paid, non-standard working hours) that participants must sometimes accept.[140]

Social inclusion and the fight against discrimination

QUÉBEC INTERVENTIONS

In order to promote social inclusion, the government has taken a number of steps, including adopting the *2010-2015 Government Action Plan for Solidarity and Social Inclusion*,[141] which aims to coordinate action to help disadvantaged individuals and to combat poverty. In the same vein, the MSSS is responsible for the new *Politique nationale de lutte à l'itinérance*[142] [national policy for combating homelessness] and the *Plan d'action interministériel en itinérance*[143] [interdepartmental homelessness action plan] and the ministère de l'Emploi et de la Solidarité sociale is responsible for the *Governmental Policy on Community Action*.[144]

People with low incomes can access legal services through the *Legal Aid*[145] program of the Ministère de la Justice [justice department]. Other measures target specific populations, including the Secrétariat à la jeunesse's [youth secretariat's] *2009-2014 Youth Action Strategy*[146] and the MFA's *Action Strategy for the Elderly*.[147]

[b] The launch of this employment strategy was followed in March 2013 by changes in the welfare policy that were strongly criticized by several groups and bodies, including the Collectif pour un Québec sans pauvreté, the Commission des droits de la personne [human rights commission] and the Québec Ombudsman (see http://www.ledevoir.com/politique/quebec/372472/aide-sociale-les-critiques-fusent-de-toutes-parts).

As regards discrimination, the National Assembly has adopted the Pay Equity Act,[148] the *Politique gouvernementale pour l'égalité entre les femmes et les hommes*,[149] [government policy on gender equality], and the *Government policy to promote participation of all in Québec's development*.[150] Finally, the Act to secure handicapped persons in the exercise of their rights with a view to achieving social, school and workplace integration[151] and the resulting policy statement *Equals in Every Respect: Because Rights Are Meant to be Exercised* [152] is championed by Québec's handicapped persons' protection office (Office des personnes handicapées du Québec or OPHQ).

Promising examples from abroad

- Australia's social inclusion policy entitled *A Stronger, Fairer Australia*[153]

This policy, aimed at families with no income, vulnerable children, the homeless, Aboriginal people, and disabled persons, proposes integrated approaches for vulnerable neighbourhoods and communities.

- Ireland's *National Plan for Social Inclusion* 2007-2016[154]

This plan aims to lift a significant number of people out of consistent poverty. It is structured around a lifecycle framework targeted at children, people of working age, older people, people with disabilities, and communities. The plan's measures comprise income support, education, employment assistance, housing, health services, and integration of immigrants.

Working conditions, health and safety

QUÉBEC INTERVENTIONS

The Act Respecting Labour Standards[155] applies to most Québec employees, but excludes self-employed workers and certain categories of employees. It covers various aspects of employment, such as minimum wage, work hours and holidays. Collective agreements between a group of employees and an employer are governed primarily by the Labour Code.[156]

In Québec, the Occupational Health and Safety Plan comprises two main laws: the Act Respecting Industrial Accidents and Occupational Diseases,[157] which provides compensation for employment injuries and the consequences they entail for beneficiaries, and the Act Respecting Occupational Health and Safety,[158] which focuses on the prevention of work accidents or occupational disease. In 2012, only 25% of Québec employees worked for companies that have a prevention program in place.

Promising examples from abroad

- Norway's Working Environment Act[159]

This Act covers workers in all industries except fishing (those workers are covered under other laws). The purpose of the Act is to ensure sound conditions of employment and equality of treatment at work. It outlines the duties of the employer and employees with regard to maintaining a satisfactory and safe working environment. The provisions relate to the general conditions of employment (work hours, contracts, holidays, hirings and dismissals), the physical and mental risks and constraints, workplace accommodations for vulnerable persons, the cooperation between employers and employees, as well as inclusion.

KEY POINTS TO NOTE ON EMPLOYMENT, INCOME AND SOCIAL SOLIDARITY

Québec has a wide range of policies relating to employment, income, and social solidarity that can contribute to reducing social inequalities. These programs and policies deserve to be maintained and, if necessary, strengthened, while taking care to develop and ensure the social participation of all citizens, which would contribute to improved quality of life and to greater social cohesion. Moreover, the impact of employment and working conditions on SIH is significant, and the examples from other countries could provide insight into how to enhance these policies (for example, higher employment standards, prevention programs in all workplaces, etc.) and, in so doing, lead to greater reductions in SIH.

6.3 Environment and land use planning

Why take action?

Land use planning does not only involve issues surrounding the economic development of a city or region, it also has the potential to influence health determinants such as housing, transportation and the environment. While land use practices directly impact these three determinants, they also affect other determinants, including air quality, safety, exposure to high traffic volume and speed, etc. Accordingly, all land use initiatives, both in urban and in rural areas, have the potential to positively or negatively influence SIH. Certain land use measures, such as the construction of high-traffic roadways, highways or polluting factories in disadvantaged neighbourhoods, contribute to increasing the burden of the most disadvantaged groups. This also helps drive more affluent and successful residents out of these neighbourhoods, further exacerbating SIH. Inversely, the implementation of healthy urban design measures (e.g., green spaces, safe bike paths) in disadvantaged neighbourhoods can mitigate SIH. The interventions that directly affect housing and mobility are levers for creating healthy environments, safe communities for all, and built environments that promote social inclusion and solidarity.

Sustainable development

QUÉBEC INTERVENTIONS

Prompted by the Sustainable Development Act,[160] the Ministère du Développement durable, de l'Environnement, de la Faune et des Parcs (MDDEFP) [department of sustainable development, the environment, wildlife and parks] developed the *Government Sustainable Development Strategy 2008-2013*[161] which aims to influence and encourage sustainable development. Preventing and reducing social and economic inequality are at the heart of this strategy.

Promising examples from abroad

- France's national sustainable development strategy

An evaluation of this strategy highlights the importance not only of implementing environmental protection measures to promote "greener" public policies, but also of developing a genuine regional development plan that focuses on the implementation of intersectoral actions to reduce inequalities.[162]

Strategic planning and revitalization

QUÉBEC INTERVENTIONS

The Act Respecting Land use Planning and Development[163] represents the legislative framework within which all urban planning and development plans in Québec must be designed, under the responsibility of the municipalities.

The *Stratégie pour assurer l'occupation et la vitalité des territoires 2011-2016*[164] [2011-2016 strategy to ensure the occupation and vitality of territories] is under the jurisdiction of the Ministère des Affaires municipales, des Régions et de l'Occupation du territoire (MAMROT) [department of municipal and regional affairs and territorial occupancy]. The Act to ensure the occupancy and vitality of territories[165] helps to achieve long-term sustainability. This national strategy offers large cities support in implementing their strategies for revitalisation urbaine intégrée (RUI),[166] [integrated urban revitalization], which are aimed at revitalizing neighbourhoods through the mobilization of citizens and partners, the implementation of poverty reduction measures, and the enhancement and improvement of built environments.

Promising examples from abroad

- Germany's *Socially Integrative City*[167] policy targeting disadvantaged neighbourhoods

This policy is the result of collaboration between the three levels of government (federal, national and local), the European Community and the private sector. Its goal is to narrow the ever-widening social gaps between neighbourhoods in Germany's cities by stabilizing and improving the physical environment and by promoting cooperation. The residents are invited to participate in the various projects, whose positive impacts include stronger social networks and more sustainable management structures.

- The Catalonian government's *Health in Neighbourhoods*[168] revitalization strategy

Intended specifically for vulnerable groups, this strategy focuses on resident involvement, intersectoral collaboration (urban planning, social services and environment), evidence-supported sustainable actions and systematic evaluations.[169] The evaluations highlight the benefits of forming an alliance between residents and stakeholders, of evaluating health needs, and of planning and proper implementation. Actively encouraged citizen involvement in the project helped to strengthen ties within

the community and to empower communities to participate in local decision making.

Housing

QUÉBEC INTERVENTIONS

As regards social housing, the Société d'habitation du Québec (SHQ) [Québec housing corporation] is responsible for coordinating the government actions outlined in its *Plan stratégique SHQ 2011-2016*[170] [2011-2016 strategic plan]. Low-income households have access to a wide variety of social housing programs managed by the SHQ,[171] the best known being the *Low-rental Housing Program*,[172] which helps offset rental costs on 63,000 dwellings. The SHQ also adopted the *Cadre de référence sur le soutien communautaire en logement social - Une action intersectorielle des réseaux de la santé et des services sociaux et de l'habitation*[173] [framework for community support for social housing – intersectoral action by the health and social services and housing networks] in collaboration with the MSSS.

With respect to the sanitation of housing units, the Municipal Powers Act[174] stipulates that any local municipality may adopt by-laws in matters of sanitation.

Promising examples from abroad

- The Welsh Assembly Government's national housing strategy referred to as Homes in Wales[175]

This strategy targets the following priority objectives: to offer a wider range of appropriate housing choices, to improve the energy efficiency of new and existing homes and to improve housing-related services and support. It comprises the Welsh Housing Quality Standard,[176] which must be met by all social housing landlords. Evidence[177] shows that this strategy has a positive impact on the mental health of tenants, on reducing the number of respiratory complaints, and on ensuring fewer visits to the doctor. Additional benefits include an investment toward achieving Welsh housing quality standards, which has proved critical to small and medium contractors, improvements to the safety and security of homes, and improvements to estates, which have helped to reduce crime and anti-social behaviour.

Transportation and mobility

QUÉBEC INTERVENTIONS

The Ministère des Transports du Québec (MTQ) [Québec department of transportation] is mandated to ensure the mobility of persons by way of effective and safe transportation systems and, as such, to establish paratransit services to meet the needs of persons with a disability, such as for example, the *Programme d'aide gouvernementale au transport adapté aux personnes handicapées*[178] [paratransit government assistance program]. The new *National Strategy for Sustainable Mobility*[179] is intended to ensure the inclusion of public transit in all significant proposals for land development. The *Québec Public Transit Policy*,[180] much like the *Bicycle Policy*,[181] is directly in keeping with the government's efforts toward achieving sustainable development.

Promising examples from abroad

- Bogota's public transportation project (in Colombia)

National policies that support municipal governance and citizen participation can also have significant benefits in terms of mobility. The success of Bogota's major transportation project is due to initiatives like *TransMilenio* (the bus rapid transit (BRT) network) and *Ciclo-Rutas* (bicycle paths), which demonstrate how much impact a strong local political will can have and just how important public-private partnerships are in the development of a transportation network. In this case, inviting citizens to participate in the decision-making process secured their support for measures such as reducing car use and promoting alternative modes of travel. In addition to reducing air pollution and traffic congestion in the capital city, these interventions fostered greater respect for public property and led to greater community involvement in civic affairs.[182]

KEY POINTS TO NOTE ON THE ENVIRONMENT AND LAND USE

In general, there are a wide range of land use intervention options for reducing SIH. It appears from the various examples outlined that synergy between national, regional and local governments as well as the involvement of citizens in decisions that affect them are factors that can positively influence policies. With regard to transportation, for example, it is important to ensure that transit users are not the only ones who get "a say" in determining which course of action to follow—individuals affected by the increasing volumes of daily travel should be consulted as well. Also considered to be a facilitating factor when preparing development plans is the parallel integration of social/cultural dimensions and economic/environmental dimensions. While several interventions exist in Québec, they do not necessarily work well in tandem or effectively reach out to the most vulnerable citizens. In the case of housing, for example, a number of interventions are designed to provide financial support, but there are no regulations requiring the inspection of buildings with indoor air quality problems and unsanitary conditions. Finally, the strategic and sustainable development plans need to be revised and updated to more effectively address issues of health and equity.

6.4 Lifestyle

Why take action?

Lifestyle choices—whether linked to food, physical exercise, use of tobacco, alcohol or other drugs that may cause dependency, gambling or other excessive behaviours—affect the health of individuals and can contribute to social inequalities in health. Unhealthy behaviours, such as smoking for example, often follow the social gradient in health, which tends to further widen the health gap between socioeconomic groups. Even though certain harmful habits, such as excessive alcohol intake, do not inherently affect disadvantaged populations, the negative effects of these habits often have a much more significant impact on the lives of economically vulnerable people. It is now recognized that lifestyle is not just a matter of individual choice or voluntary behaviour, and that it is influenced by all of the determinants. Interventions that are designed to change unhealthy lifestyles by influencing social determinants of health, such as those targeting the built environment, for example, represent interesting avenues for tackling SIH. However, scientific data on the effectiveness of behaviour-changing interventions on social inequalities in health are still fragmented.[183] The literature shows that a strong association exists between high social status and the use of prevention and health promotion services. Moreover, several studies highlight the difficulty in reaching the most disadvantaged segments of the population.[184] When interventions are focused on changing lifestyle habits or health behaviours among the general population, SIH are often shown to increase since these measures fail to reach the most economically disadvantaged members of society. Therefore, special attention must be paid to adapting these health promotion interventions for vulnerable groups.

Promotion of healthy lifestyles and prevention of obesity

QUÉBEC INTERVENTIONS

The MSSS was involved in developing the government action plan *Investir pour l'avenir : Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids 2006-2012*[185] in collaboration with seven departments and three government agencies.

Since June 2006, the Act to Establish the Sports and Physical Activity Development Fund[186] has offered financial support to municipalities, educational organizations and non-profit organizations for the construction, renovation, equipping and bringing up to standards of sports and recreational facilities.

The *Programme Kino-Québec*[187] [Kino-Québec program] aims t**o** promote a physically active lifestyle and is managed jointly by the MELS, the MSSS and the health and social services agencies.

In 1997, the *Programme éducatif en services de garde*[188] [an educational child care program] was implemented to promote child development. It focuses on prevention and promotion in order to create an environment that is conducive to the adoption of healthy eating habits, lifestyle and behaviours.

The above programs are intended for the general population and are not proportionately targeted to vulnerable individuals, even though, in fact, the PNSP recognizes that the fight against SIH is a priority. Their contribution to reducing social inequalities in health has not been demonstrated.

Promising examples from abroad

- Slovenia's *Programme MURA*[189] to promote better health and development in a disadvantaged region

This national program was implemented in Pomurje, the country's poorest community. Developed with a consortium of partners from the health sector and the agri-food and tourism industries, this program is intended to ensure the delivery of good quality, safe products from the farm to the table, the production of more fruits and vegetables, and the promotion of sustainable production practices and shorter production chains. The tourism industry focuses on developing ecotourism infrastructure and promoting food products and recreational activities that are conducive to good health. The program includes activities that promote healthy lifestyles among the local population, for marginalized groups, and in schools. The evaluations showed a significant impact on population health.

- The promotion of healthy lifestyles in northern Europe

In 2006, the *Nordic Council* launched a plan of action entitled *Nordic Plan of Action on better health and quality of life through diet and physical activity*[190] that supports targeted actions directed at vulnerable at-risk groups and aims to bridge the health behaviour gaps among the different socioeconomic groups. Note that Finland is recognized for its interventions of this nature, such as the *North Karelia Project*,[191] for example, implemented in the early 1970s, which has helped to create more homogeneous dietary habits across different socioeconomic groups.

- The Norwegian plan entitled *Norwegian Action Plan on Nutrition (2007-2011) – "Recipe for a healthier diet"*[192]

This plan is directly aimed at reducing social inequalities in diet. It outlines interventions to be implemented in schools, workplaces and health institutions and includes, among other things, low-cost, subsidized access to healthy meals in schools and daycares. Another intervention consists in tailoring nutrition information to different target groups.

Food safety

QUÉBEC INTERVENTIONS

The MSSS's *Cadre de référence en matière de sécurité alimentaire*[193] [reference framework for food security] is aimed at promoting concerted collective action on the key environmental and individual determinants of food security. The primary purpose is to improve physical and economic access to healthy food for people living in poverty.

Promising examples from abroad

- The United Kingdom's Food Poverty Eradication Bill[194]

One of the project's measures consists in ensuring disadvantaged neighbourhoods have easier access to high-quality foods. Two supermarkets opened up in lower-income neighbourhoods, and one study showed a noticeable improvement in the residents' eating habits.[195]

Tobacco, alcohol, drugs, other substances and gambling

QUÉBEC INTERVENTIONS

Under the Tobacco Act[196] passed in 2006, it is forbidden to smoke in public spaces and to sell or supply tobacco to a minor on the grounds or within the premises of buildings placed at the disposal of a school. This Act also outlines legislative measures regarding the advertising of tobacco products and restrictions on points of sale.

The objectives of the MSSS's *Plan québécois de prévention du tabagisme chez les jeunes 2010-2015*[197] [2010-2015 Québec plan for the prevention of teen smoking] are to prevent people from starting to smoke, to help smokers to quit and to protect people from exposure to environmental tobacco smoke (ETS).

To prevent, reduce and treat the individual and collective problems that arise from substance abuse, the MSSS and nine other departments are working on implementing the *Plan d'action interministériel en toxicomanie 2006-2011*[198] [2006-2011 inter-departmental action plan on substance addiction]. This plan focuses on prevention, early intervention, treatment and social reintegration.

However, these interventions do not focus specifically on reducing social inequalities in health, although some are intended to reach vulnerable groups within the population.

Promising examples from abroad

- Australia's national framework for action entitled *National Drug Strategy 2010–2015*[199]

This framework for action, in place since 1989, involves all levels of government, the non-governmental sector, and communities. One of the pillars of this policy is its support of efforts to promote social inclusion and resilient individuals, families and communities by adopting a harm minimization approach.

- New Zealand's plan to reduce harm caused by gambling entitled *Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11—2015/16*[200]

The overall goal of this plan is to specifically reduce health inequalities related to problem gambling. It proposes an integrated approach that involves the participation of government, industry, communities, and families in prevention-focused interventions.

KEY POINTS TO NOTE ON LIFESTYLE

Stemming from either an environment-based approach or an approach focused on changing individual behaviours, the interventions (in Québec and globally) presented herein call on many different sectors and cover a wide range of topics. Several of the interventions implemented elsewhere in the world appear promising with regard to reducing SIH, such as actions focused on eating habits, on increasing the availability of healthy food, or even on increasing tobacco prices. However, evidence is still fragmented and is often mixed with regard to the effectiveness of lifestyle-improvement interventions and their impact on reducing SIH, which complicates the decision-making process for governments. Some of the projects specifically targeted at disadvantaged neighbourhoods, such as Slovenia's *Programme MURA* or Finland's *North Karelia Project*, produced noteworthy results. These targeted approaches help reach out to vulnerable populations who tend to use fewer services or are less receptive to universal prevention campaigns. With regard to mobilizing stakeholders around the importance of acting on lifestyles, we can assume that the top international priorities adopted by organizations such as the WHO, for example, help foster the mobilization of actors around shared priorities for action.[201]

6.5 Health care and services

Why take action?

Universality, socialization, equity, and quality health care and services help to prevent further widening of SIH. Access to health care and services, in other words obtaining health services that meet a need or a desire for care, is particularly important given that studies in Europe show that socioeconomically disadvantaged groups tend to rely less on health care services (whether preventive or curative), which leads to a worsening of health problems among these populations.[202] [203] [204] Access to care can be limited by several factors related to socioeconomic status, to a lack of infrastructure and personnel, and even to geographical, linguistic or cultural barriers. Consequently, interventions that facilitate access to quality care for the most vulnerable groups must be an integral part of the fight against SIH. Universal health coverage, organization of care based on the needs of targeted populations, and community capacity building are among the measures outlined in the scientific literature which would help ensure that vulnerable members of the population have easier access to care.

Universal coverage

QUÉBEC INTERVENTIONS

The *Québec Health Insurance Plan (RAMQ)*[205] entitles all residents of Québec to obtain medical services free of charge. The medical services covered by the Health Insurance Plan are those that are medically necessary and rendered by a general practitioner (also called a "family doctor") or a medical specialist. The Plan also covers dental and optometry services for certain clients, including children, the elderly and people who have been on social assistance or welfare for at least one year. Another universal public plan that provides free access to hospital services is the Hospital Insurance Plan.[206] Finally, the *Public Prescription Drug Insurance Plan*[207] is intended for persons who do not have private insurance to cover medication costs.

Promising examples from abroad

- Universal health care coverage in France

In France, universal health coverage protects the population from the main costs associated with potential future illness. The Law of July 27, 1999 establishing a system of universal health care coverage [*Couverture maladie universelle* or *CMU*] provides all residents with free access to care with a minimum of bureaucracy involved. This law extends coverage to people previously excluded

and offers supplementary health insurance to people with low incomes. However, access to universal care remains a challenge. In 2004, 13% of the French population deprived themselves of medical care (dental services, eyeglasses or other specialized care) for financial reasons.[208] Moreover, illegal immigrants (without official papers) and financially challenged patients (people with a low income, the homeless, etc.) do not always have access to the care they require, and there are still many social and geographical barriers. These deficiencies in universal coverage have been identified in several European countries that offer universal health care.[209]

- Reimbursement for dental care in Finland

The case of Finland, where private dental care expenses for all age groups have been covered since 2001-2002, is an exception. On implementation of this measure, the country experienced a significant increase in the use of dental services. However, it is worth noting that despite having easy access to such care, people with lower levels of education still tend not to use these services very often.[210] [211]

Organization and access to care

QUÉBEC INTERVENTIONS

The organization model described in the Act respecting health services and social services (Loi québécoise sur les services de santé et les services sociaux or LSSSS)[212] is based on three levels of government—central, regional and local—and on complementarity between institutions. At the local level, the local service networks unite all health and social services actors under one institution called a Health and social services centre (Centre de santé et de services sociaux or CSSS).[213] The CSSS must mobilize other regional partners such as community organizations, social economy enterprises, and education and municipal partners, in order to define the population's social and health needs and to identify health improvement goals, what services to offer, and how to organize them. The CSSS's services must meet the needs of the entire population within its territory, including vulnerable or low-income individuals, even if these people do not directly seek care from these institutions. This approach, which coordinates the provision of services on the basis of a population in a given area, rather than on the basis of individuals who directly access services, is called "population-based responsibility".

The mission of the Health and Welfare Commissioner (Commissaire à la santé et au bien-être or CSBE)[214] is to appraise the performance of Québec's health and social services system and to formulate recommendations concerning the system's performance, specifically with regard to service access and ethical concerns. The Commissioner's recent reports on front-line care,[215] on perinatal and early childhood services [216] and on mental health services,[217] among others, outline recommendations for better access to services for disadvantaged groups.

Promising examples from abroad

- The United Kingdom's health care policy for the elderly entitled *National Service Framework for Older People*[218]

In 2001, the United Kingdom implemented this policy aimed at providing older people with fair, reasonable access to integrated health and social care services. The policy stresses the necessity of supporting independence, promoting health and advocating for culturally appropriate service delivery systems so that older people and their caregivers are treated with respect, dignity and equity. However, an evaluation conducted among older people shows that despite an improvement in wait times and in the effectiveness of front-line care, gaining access to a physician remains a challenge, and the overall perception is that the assistance offered is fragmented and impersonal and that hospitals are high-risk, poorly organized places.[219] The *LinkAge Plus*[220] pilot programme and the *Partnerships for Older People*[221] projects helped extend the working principles, improving access for older people. Research into geriatric medicine is considered essential to understanding the experience of older people and tailoring services to their needs.

- Integration of mental health services

Despite the modest results reported thus far, integration of mental health care into primary health care services presents another avenue that may mitigate SIH. Research shows that there are several advantages to undertaking a holistic approach to mental and physical health, particularly in terms of accessibility and financing.[222] Over the last 20 years, the government in the United Kingdom has invested heavily in community care, acting in concert with social services to move toward integrating mental health care into primary care services and toward establishing links between primary and secondary care. More recently, the government presented a strategy entitled *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*,[223] one of its objectives is directly focused on creating pathways to mental health care for everyone. Each objective outlined in this strategy was assessed in terms of its impact on equity[224] for the different population

groups (on the basis of age, sex, ethnic origin, sexual orientation, etc.).

Strengthening health competencies within communities

QUÉBEC INTERVENTIONS

A health-based study program (100 hours) is part of the MELS's *Government Policy on Adult Education and Continuing Education and Training*.[225] Its aim is to lay the groundwork for responsible and preventive health-related actions through the acquisition of competencies applicable in real-life situations, where behaviour management is addressed from the perspective of nutrition, physical exercise, recreation, or recovery.

Promising examples from abroad

- The MiMi programme (*With Migrants for Migrants*) in Germany[226]

The goal of the program is to render the health system more accessible to immigrants, by increasing health literacy while simultaneously empowering immigrant communities to engage with the health system. By focusing on citizen participation and on individual responsibility for one's health, immigrants are encouraged to engage in learning that will help them obtain care and services that meet their needs. Knowledge sharing on how the health care system works and on how to access resources is accomplished through intercultural mediators from within the community. In addition, health professionals are encouraged to improve their knowledge about the communities. The programme was initially launched as a pilot project in four German cities and has currently expanded to 48 municipalities. The evaluations conducted among programme participants show a marked increase in the number of immigrants who accessed health care and services.[227] [228]

KEY POINTS TO NOTE ON HEALTH CARE AND SERVICES

Interventions affecting the health care and services system can mitigate or entrench SIH. Universal health coverage can be viewed as a measure that promotes equity, but it also raises a number of issues, in particular, regarding access to and quality of services. One way to address the challenge of accessibility consists in tailoring services to the needs of the most vulnerable groups, with the aim of reducing their risk of being marginalized. The difficulties encountered in obtaining access to care demonstrate just how important it is for health service professionals to be attentive to the specific needs of certain populations (the elderly, immigrants, etc.), and, to a greater degree, just how important the community's contribution is in identifying and managing these needs. More research is needed, particularly regarding health literacy, for which very few rigorous evaluations have been carried out to examine the effectiveness of measures implemented in Canada or abroad.

KEY POINTS TO NOTE ON GOVERNMENT INTERVENTIONS FOCUSED ON DETERMINANTS

The determinant-based interventions outlined in this section emanated from a number of sectors, including that of health. These types of interventions, for example revenue support or municipality revitalization measures, do not usually focus on SIH or on health. Some measures focus on prosperity or economic development, which obviously have an indirect impact on SIH and on health. Several interventions that stem from environment-based approaches, for example community development, affect many determinants and are considered to be intersectoral projects.

This overview demonstrates that **political mobilization** around the interventions adopted is crucial. We can assume that the top priorities adopted by governments and international organizations such as the WHO help foster stakeholder commitment to shared priorities for action, such as fighting obesity or sustainable development, by affirming the relevance of interventions in such areas. It is interesting to note that a strategic issue such as sustainable development, which aims to promote social and economic prosperity, can align with the fight against SIH, as the United Kingdom and French initiatives clearly show, provided the interventions adopted focus on social dimensions and not only on environmental protection. **Intersectoral projects** focused on economic development, such as Slovenia's *Programme MURA* (health, agri-food, tourism, and transportation), have resulted in positive benefits for disadvantaged populations.

Several foreign initiatives highlight the relevance of **citizen participation** in interventions. Accordingly, several projects in England, Spain and Germany have shown that consulting local residents about which interventions to choose and how to implement them not only has a positive effect on community participation and on the ability of interventions to adequately meet needs, it also promotes the social inclusion of disadvantaged populations. Furthermore, these experiences show that citizen participation strengthens social networks.

This summary review also highlights the importance of the **quality of the interventions** implemented. Creating jobs that are risky or hazardous to health or building low-quality social housing will have little impact on reducing SIH or on health. In terms of housing, for example, the Welsh Housing Quality Standard proved very useful for improving tenant health, and in the early childhood services sector, foreign experiences show that the quality of daycare services and interventions among disadvantaged children is crucial.

In addition to the requirements concerning quality, it appears that **integrated services** are often needed to ensure improved access for disadvantaged segments of the population; coherence among the different services for vulnerable people is fundamental to ensuring their participation in these interventions.

Finally, two challenges appear to be associated with interventions targeting determinants of health, and these tie in with those identified for comprehensive approaches. First, the limited **results regarding the impact** of these interventions on health and on SIH makes prioritizing the most effective interventions very difficult. Second, effectively **reaching the most vulnerable segments of the population** is also difficult, given that these individuals rarely use public services, even when the services are free and easily accessible. Actions specifically targeting disadvantaged neighbourhoods (*MURA*, *North Karelia Project*) produced noteworthy results in terms of promoting healthy lifestyles. This type of targeted strategy nonetheless runs the risk of creating stigmatization, which can, however, be lessened by focusing on a community sector, rather than on a socioeconomic group much like the United Kingdom's *Sure Start* initiative, for example.

7 Challenges and limitations of government interventions to reduce SIH

The information in this document demonstrates that governments can, through comprehensive strategies aimed at combatting SIH, adjust their economic, social and health policies so as to promote social equity. The comprehensive strategies outlined in this review are the product of many years of hard work. Their adoption and implementation are made possible because of political will and stability, the promotion of justice and equity as social values, and intersectoral governance that mobilizes the various sectors and levels of government. Despite the effort invested, these large-scale initiatives do not always produce the desired results. Even though they often promote health improvement for all social groups, they often fail to reduce health disparities between groups. Sectoral or cross-sectoral interventions that focus more specifically on particular determinants of health can strengthen these global approaches because they have a more direct bearing on SIH, particularly interventions aimed primarily at promoting more egalitarian access to resources, such as interventions focused on income, work, and access to education and services are avenues to be promoted, as proposed by Link and Phelan (8). Moreover, the mobilization of different actors around shared priorities for action, citizen participation in interventions, high quality interventions, and the integration of services to facilitate their access represent other conditions likely to ensure successful, effective implementation of these measures.

However, combatting SIH can sometimes cause unwanted effects, such as when government interventions threaten to widen health gaps. In fact, foreign experiences demonstrate that it can be difficult to reach the most disadvantaged populations and that the implementation of universal strategies can, in some cases, inadvertently increase SIH by more successfully reaching advantaged groups, even if progress can be observed among more disadvantaged groups. Hence, the challenge is to find a balance between universal measures that affect the entire population and measures that proportionately target disadvantaged groups, while being careful not to stigmatize them.

Québec interventions to reduce social inequalities in health

Political action in Québec has often been guided by values tied to social justice, effectively positioning the province as a leader in the fight against poverty in Canada and North America.[229] However, Québec could play a more active role, much like certain European countries that are clearly committed to developing their own social policies. In addition, more than ten years after the Act to combat poverty and social exclusion was adopted, a review of its benefits and of the impact of its social measures on poverty would prove valuable to guiding intervention targeting SIH. It is well known that many of the measures adopted by the Québec government, such as family allowances, parental leave and the $7-per-day daycare program, protect middle-class families and children.[230] Drug insurance, the work premium, employment support measures, and the indexation of social assistance benefits are other examples of measures identified as having contributed to recent successes (62). Québec has also performed well with regard to healthy lifestyle interventions, although the latter contribute very minimally to reducing SIH. Therefore, government maintenance and strengthening of sustained interventions in the areas of social protection and health is key to reducing SIH.

In Québec, several policy avenues can be considered for specifically tackling SIH. To begin with, the promotion of a shared vision for reducing SIH that mobilizes all activity sectors, departments and key organizations could lead to more accurate assessment of how SIH can be taken into consideration during the policy development and adoption process. Reference to a shared vision could ensure greater consistency in government action and, thereby, prevent policies implemented in one sector from cancelling out the efforts undertaken in other sectors. The strengthening of intersectoral governance within government would serve to modernize this vision and ensure better coordination of interventions.

Québec already has several levers for promoting intersectoral governance, including Section 19 of the Act to Combat Poverty and Social Exclusion; Section 54 of the Public Health Act (which includes a health impact assessment mechanism); the *Government Sustainable Development Strategy*; the *Community development strategy*; and the standing ministerial committees.

In the same vein, the progress made with respect to social protection, the fight against poverty, and actions addressing the determinants of health could be consolidated both by ensuring that existing policies and measures are fully implemented, sustainable and of good

quality, and by ensuring that services for vulnerable people are effectively integrated. Accordingly, several of the foreign initiatives outlined in this document could prove quite useful.

In addition, involving the community sector and citizens in decision-making and in the monitoring of interventions is a prerequisite for reaching vulnerable and disadvantaged populations. Since inequalities often go hand in hand with social exclusion and stigmatization, it is important to include populations targeted by the interventions in the decision-making process. This would help to increase understanding of the issues associated with SIH, to develop solutions that are better tailored to reality, and to give a voice to people who are often not heard. Since the Aboriginal population is particularly vulnerable with respect to health, Québec's commitment to reducing SIH should also comprise a separate component tailored to the specific contexts of Aboriginal communities. Greater synergy between government intervention and social action (community interventions, citizens' initiatives, etc.) should also be promoted.

Of equal importance is the establishment of an official, recognized system for measuring and tracking changes in SIH over time. Based on the work done by the Commission on Social Determinants of Health, the World Health Organization (2011)[231] recommends that countries seeking to steer development along a path toward health equity should, at the very least, implement a system for systematically evaluating SIH. This system, comprising several key indicators, would make it possible to conduct regular ongoing assessments of the gains achieved or, conversely, of the widening gaps between certain population groups. Hence, it would guide review of the impacts generated by measures intended to mitigate SIH. Québec recently chose to pursue this avenue by conducting a reflective review process involving national and regional public health actors, who examined options for systematically monitoring social inequalities in health, with the importance of sustaining such a system being understood.[232] Finally, knowledge development and scientific monitoring of the effectiveness of government interventions on SIH would help guide the government through the process of selecting and reviewing its interventions.

It is obvious that the problem of SIH is vast and complex and that unequal power dynamics and exclusion, as well as certain policies and social norms and practices generate social and health disparities. Therefore, government intervention to reduce SIH is anything but simple, and necessarily takes place within a specific context and involves a set of interventions. There is no scientific consensus regarding how to effectively take action to reduce SIH. However, the need to take SIH into account when considering government intervention, at the very least to avoid worsening the situation, is acknowledged by experts. In addition, this review demonstrates that to reduce SIH, social policies must be strengthened both at the level of the general population (universal interventions) and at that of disadvantaged populations (targeted interventions), without stigmatizing the latter. Consequently, proportionately targeted interventions, or actions that target the general population, in conjunction with intervention that is modulated according to the social gradient of health, should be preferred and strengthened.

Québec's approach to social policies often reflects this perspective, favouring the association of universal interventions with proportionately targeted interventions. The Québec government could take a more specific and declarative stance in the fight against SIH by exploring the proposed policy avenues and enhancing its policies in light of the multiple examples presented in this document.

References

1 Noël, Alain (2009). La loi 112 et les inégalités sociales, *Revue Développment Social, Volume 10* (2). Retrieved from: http://www.revueds.ca/la-loi-112-et-les-inegalites-sociales.aspx

2 Raynault, Marie-France (2009). Les inégalités sociales, un choix de société? *Revue Développement Social, Volume 10*(2). Retrieved from: http://www.revueds.ca/les-inegalites-sociales-un-choix-de-societe.aspx

3 Phelan, J.C., Link, B.G., Tehranifar, P. (2010). Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications. *Journal of Health and Social Behavior, 51*(1), S28.

4 WHO (2008). *Closing the Gap in a Generation: Health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. Geneva.

5 St-Pierre, L. et Gauvin, F.-P. (2010). Intersectoral governance for Health in All Policies: an integrated framework. Public Health Bulletin SA. Adelaide 2010 International Meeting, 7(2), 31-36. http://www.health.sa.gov.au/pehs/publications/public-health-bulletin.htm

6 Puska, P. (2007). Editorial: Health in all policies. *European Journal of Public Health, 17,* (4), 328.

7 WHO Regional Office for Europe (1999). *Health Impact Assessment: main concepts and suggested approach*: Gothenburg consensus paper.

8 Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications*. Journal of Health and Social Behavior*, *51*, S28.

9 Racine, S. (2007). Un tour d'horizon de l'exclusion. *Service social, nº. 53,* Vol 1. Retrieved from: http://id.erudit.org/iderudit/017990ar

10 Pampalon, R., Hamel, D., & Gamache, P. (2008). *Les inégalités sociales de santé augmentent-elles au Québec?* Québec: Institut national de santé publique, 19 pp.

11 Pampalon, R., Hamel, D., & Gamache, P. (2010). Health inequalities in urban and rural Canada: Comparing inequalities in survival according to an individual and area-based deprivation index. *Health and Place*, *16*, 416-420.

12 Direction de santé publique-Agence de la santé et des services sociaux de Montréal (2012). *Report of the Director of Public Health. Social Inequalities in Health in Montréal. Progress to Date* (2nd ed., pp. 15-16).

13 Pampalon, R. D. Hamel, P. Gamache et G. Raymond, 2009. «Un indice de défavorisation pour la planification de la santé au Canada», *Maladies chroniques au Canada*, 29 (4) : 199-213.

14 Infocentre de santé publique du Québec, 2012. Indicateurs du plan commun de surveillance, [en ligne]. [www.infocentre.inspq.rtss.qc.ca/].

15 Institut national de santé publique du Québec, 2012. Données inédites.

16 Lasnier, B, B.-S. Leclerc et D. Hamel, 2012. *Les inégalités sociales de santé en matière de tabagisme et d'exposition à la fumée de tabac dans l'environnement au Québec*, Montréal, Institut national de santé public, 54 p.

17 Examination of death certificates at two points in time (1996 and 2006) allows for the quantification of the gap in life expectancy at birth for men and for women, according to how disadvantaged they are. It is thus possible to monitor the evolution over time of SIH as regards mortality.

18 This study on the health gaps in urban centre in Canada is based on the application of the deprivation index to hospitalization data for the years 2003-2004 to 2005-2006 and to data from health surveys of Canadian communities from 2003 and 2005: Canadian Institute for Health Information (2008). *Reducing the Gaps in Health: A Focus on Socio-Economic Status in Urban Canada.* Ottawa (ON), 149 pp.

19 Department of Economic and Social Affairs of the United Nations Secretariat (2009). *State of the World's Indigenous Peoples.* New York: United Nations Publications.

20 Adelson, N. (2005). The Embodiment of Inequity Health Disparities in Aboriginal Canada. *Canadian Journal of Public Health, 96* (Supp 2), S45-S61.

21 RRSPQ (2008). *Jeunesse autochtone et inégalités sociales de santé, Carnet-synthèse 4* (July 2008). Réseau de recherche en santé des populations du Québec.

[22] Czyzewski, K. (2011). Colonialism as a Broader Social Determinant of Health. *The International Indigenous Policy Journal, 2*(1). Retrieved from: http://ir.lib.uwo.ca/iipj/vol2/iss1/5

[23] Reading, C. L., & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal Peoples' health*. Prince George: National Collaborating Centre for Aboriginal Health.

[24] MSSS (2011). *Pour guider l'action. Portrait de santé du Québec et ses régions. Cinquième rapport national sur l'état de santé de la population*.

[25] Vézina, M. et al (2011). *Résumé. Enquête québécoise sur les conditions de travail, d'emploi et de santé et de sécurité du travail (EQCOTESST)*. Institut de recherche Robert-Sauvé en santé et sécurité du travail.

[26] Institut de la statistique du Québec. *Le Québec chiffres en main, édition 2012*.

[27] Government of Québec, Conseil du statut de la femme. *Portrait des Québécoises en 8 temps. Édition 2012*. Retrieved from: http://www.csf.gouv.qc.ca/modules/fichierspublications/fichier-37-1646.pdf

[28] Mackenbach, J.P. (2011). Can we reduce health inequalities? An analysis of the English strategy (1997-2010), *Journal of Epidemiology in Community Health*, *65*, 568-575. Retrieved from: http://jech.bmj.com/content/65/7/568.full

[29] Moberg, H. (2008). Comparative Studies of policies on health inequalities – a literature review. In Hogstedt, C., Moberg, H., Lundgren, B., Backhans, M. (Eds.), *Health for All? A Critical Analysis of Public Health Policies in Eight European Countries.* Swedish National Institute of Public Health, p. 20.

[30] Hogstedt, C., Moberg, H., Lundgren, B., & Backhans, M. (Eds.) (2008). *Health for All? A Critical Analysis of Public Health Policies in Eight European Countries*, Swedish National Institute of Public Health, p. 116.

[31] UK Government, Department of Health (2011). *Healthy lives, healthy people: update and way forward*. https://www.gov.uk/government/publications/healthy-lives-healthy-people-update-and-way-forward

[32] Acheson, Sir Donald (1998). *Independent Inquiry into Inequalities in Health Report*. Department of Health, UK Government.

[33] UK Government, Department of Health (1999). *Saving Lives: Our Healthier Nation.* Retrieved from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4049329.pdf

[34] UK Government, Department of Health (1999). *Reducing Health Inequalities: An Action Report.* Retrieved from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4042496.pdf

[35] UK Government, Department of Health (2003). *Tackling Health Inequalities: A Programme for Action*. Retrieved from: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4019362.pdf

[36] UK Government, National Audit Office (2010). *Tackling inequalities in life expectancy in areas with the worst health and deprivation*.

[37] Marmot, Sir Michael (2010). *Fair Society, Healthy Lives (The Marmot Review).* UK. Retrieved from: http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[38] According to the European portal for Action on health Inequalities website (http://www.health-inequalities.eu/HEALTHEQUITY/EN/about_hi/health_inequalities/finland/), there is no English version of this document. The comments on its content in the present text are taken from the *Health 2015 Public Health Programme.*

[39] Government of Finland, Ministry of Social Affairs and Health (2001). *Government Resolution on the Health 2015 public health programme*. Retrieved from: http://pre20031103.stm.fi/english/eho/publicat/health2015/health2015.pdf

[40] Government of Finland, Ministry of Social Affairs and Health (2008). *National Action Plan to Reduce Health Inequalities 2008-2011*. Retrieved from: http://pre20090115.stm.fi/pr1227003636140/passthru.pdf

[41] Government of Finland, Ministry of Social Affairs and Health (2010). *Socially sustainable Finland 2020. Strategy for social and health policy.* Retrieved from: http://www.stm.fi/c/document_library/get_file?folderId=2765155&name=DLFE-15321.pdf

[42] Government of Sweden, Swedish National Institute of Public Health (2003). *Sweden's New Public-Health Policy*. Retrieved from: http://www.jointcenter.org/hpi/sites/all/files/07-Sweden's%20New%20Public-Health%20Policy.pdf

[43] Government of Sweden. *Policy areas. Youth Policy*. Retrieved from: http://www.government.se/sb/d/3781/a/172092

[44] Government of Sweden, Swedish National Institute of Public Health (2011). *Public health of the future – everyone's responsibility. A summary of the Swedish Public Health Policy Report 2010*. Retrieved from: http://xn--folkhlsostmman-9hbf.se/en/Publications/All-publications-in-english/Public-health-of-the-future--everyones-responsibility-A-summary-of-the-Swedish-Public-Health-Policy-Report-2010/

[45] See the statistical data compiled by the Norwegian Institute of Public Health. Retrieved from: http://www.fhi.no/eway/default.aspx?pid=238&trg=MainLeft_5976&MainArea_5811=5976:0:15,5012:1:0:0:::0:0&MainLeft_5976=5825:74845::1:5977:18:::0:0

[46] See the *Human Development Report 2011: Sustainability and Equity: A Better Future for All*. *United Nations Development Programme (UNDP)*. Retrieved from: http://hdr.undp.org/en/content/human-development-report-2011

[47] Government of Norway, Ministry of Health and Care Services (MHCS) (2011). The Norwegian Public Health Act. Retrieved from: http://www.regjeringen.no/upload/HOD/Hoeringer%20FHA_FOS/123.pdf

[48] Government of Norway, Directorate for Health and Social Affairs (2005). *The Challenge of the Gradient.* Retrieved from: http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/ev_060302_rd01_en.pdf

[49] Government of Norway, Ministry of Health and Care Services (2007). *National strategy to reduce social inequalities in health*: *Report to the Storting No. 20*. Retrieved from: http://ec.europa.eu/health/ph_determinants/socio_economics/documents/norway_rd01_en.pdf

[50] Government of Norway, Ministry of Health and Care Services (2006). *National Health Plan for Norway (2007–2010): Proposition to the Storting No. 1 (2006-2007) Chapter 6*. Retrieved from: http://www.regjeringen.no/upload/HOD/National%20health%20plan_eng_06052007.pdf

[51] Government of Norway, Royal Norwegian Ministry of Labour and Social Inclusion (2006-2007). *Work, Welfare and Inclusion: Report to the Storting No. 9*. Retrieved from: http://www.regjeringen.no/Upload/AID/vedlegg/stmeld_9_2006_english.pdf

[52] Government of Norway, Royal Norwegian Ministry of Labour and Social Inclusion (2009). *Action Plan against Poverty. Status 2008 and intensified efforts 2009.* Retrieved from: http://www.regjeringen.no/upload/AID/publikasjoner/rapporter_og_planer/2008/Hplan_2008_fattigdom_english.pdf

[53] Government of Norway, Norwegian Ministry of Education and Research (2006-2007). *Early Intervention for Lifelong Learning. Summary of Report No. 16 to the Storting*. Retrieved from: http://www.regjeringen.no/Rpub/STM/20062007/016EN/PDFS/STM200620070016000EN_PDFS.pdf

[54] Bryant, T. (2012). Applying the Lessons from International Experiences. In Raphael, D. & Scott-Samuel, A., *Tackling Health Inequalities. Lessons from International Experiences*, p. 273.

[55] Mahoney, M., Simpson, S., Harris, E., Aldrich, R. & Stewart Williams, J. (2004). *Equity Focused Health Impact Assessment Framework*. Newcastle: CHETRE UNSW and ACHEIA. Retrieved from: http://hiaconnect.edu.au/old/files/EFHIA_Framework.pdf

[56] Website of the Australian Health Inequities Program: http://som.flinders.edu.au/FUSA/PublicHealth/AHIP/about.htm

[57] Australian Government. *Closing the Gap: Indigenous Reform Agenda*. Retrieved from: http://www.fahcsia.gov.au/our-responsibilities/indigenous-australians/programs-services/closing-the-gap

[58] Australian Government (2010). *Taking Preventative Action. A response to Australia: The Healthiest Country By 2020*. Report of the National Preventative Taskforce. Commonwealth of Australia.

[59] Australian Government. *Australian National Preventive Health Agency, Strategic Plan 2011-2015*, p. 13.

[60] NWS Department of Health (2004). *In All Fairness: Increasing equity in health across NSW. NSW Health and Equity Statement.* Retrieved from: http://www0.health.nsw.gov.au/pubs/2004/pdf/fairness.pdf

[61] WHO World Conference on Social Determinants of Health (2011). Closing the Gap: Policy into practice on Social Determinants of Health – Discussion paper.

[62] New Zealand Government. Ministry of Health. Reducing Inequalities in Health: http://www.health.govt.nz/publication/reducing-inequalities-health

[63] Information on the program *Working for Families*. Retrieved from: http://www.msd.govt.nz/about-msd-and-our-work/work-programmes/policy-development/working-for-families/future-directions-working-for-families.html

[64] Information on *Whānau Ora.* Retrieved from: http://www.health.govt.nz/our-work/populations/maori-health/whanau-ora

65 Signal, L., Martin, J., Cram, F., & Robson, B. (2008). *Health Equity Assessment Tool: A User's Guide*. Wellington, New Zealand: Ministry of Health. Retrieved from: http://www.health.govt.nz/publication/health-equity-assessment-tool-users-guide

66 Information on the *Public Health Bill.* Retrieved from: http://www.health.govt.nz/about-ministry/legislation-and-regulation/legislation-ministry-administers/public-health-bill

67 Noël, Alain (2009). La loi 112 et les inégalités sociales. *Revue Développment Social, Volume 10*, No 2. Retrieved from: http://www.revueds.ca/la-loi-112-et-les-inegalites-sociales.aspx

68 Government of Québec (2001). Public Health Act. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_2/S2_2_A.html

69 Government of Québec (2002). An Act to Combat Poverty and Social Exclusion. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/L_7/L7_A.html

70 Government of Québec, MSSS (2005). *Article 54 de la Loi sur la santé publique. Bilan de mise en oeuvre Juin 2002 – Janvier 2005*. Retrieved from: http://politiquespubliques.inspq.qc.ca/fichier.php/60/Bilanarticle54.pdf

71 Conseil exécutif, Secrétariat des comités ministériels. Retrieved from: http://www.mce.gouv.qc.ca/comites_ministeriels/secretariat_comites_ministeriels_en.htm

72 Government of Québec (2002). An Act to Combat Poverty and Social Exclusion. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/L_7/L7_A.html

73 Government of Québec (2002). *National Strategy to Combat Poverty and Social Exclusion: The Will to Act, The Strength to Succeed.* Retrieved from*: http://www.mess.gouv.qc.ca/grands-dossiers/lutte-contre-la-pauvrete/index_en.asp*

74 National Collaborating Centre for Healthy Public Policy (NCCHPP) (2009). *An Act to Combat Poverty and Social Exclusion (R.S.Q., chapter L* *-7) – Highlights of the Santé publique Québec.* Retrieved from: http://www.ncchpp.ca/docs/Loi112FactsApplicationEN.pdf

75 Government of Québec, Ministère du Développement durable, de l'Environnement et des Parcs (MDDEP) (2007). *Government Sustainable Development Strategy 2008-2013*. Retrieved from: http://www.mddep.gouv.qc.ca/developpement/strategie_gouvernementale/strat_gouv_en.pdf

76 MDDEP. Comité interministériel du développement durable. Retrieved from: http://www.mddep.gouv.qc.ca/developpement/comite_en.htm

77 Government of Québec, Ministère de la Santé et des Services Sociaux (2008). *Québec Public Health Program*. Retrieved from: http://msssa4.msss.gouv.qc.ca/en/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/18bad42cc1a754e98525753c00650c3b?OpenDocument

78 Ridde, V. (2007). Reducing social inequalities in health: public health, community health or health promotion? *Promotion & Education, vol. XIV*, no. 2. IUHPE.

79 Comité ministériel sur la réduction des inégalités de santé et de bien-être liées à la pauvreté 2002. *La réduction des inégalités liées à la pauvreté en matière de santé et de bien-être : Orienter et soutenir l'action!* Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2003/03-207-01.pdf

80 http://www.mediak.ca/

81 Direction de la santé publique de Montréal-centre (2011). Report of the Director of Public Health: Social Inequalities in Montreal: Progress to Date. Retrieved from: http://publications.santemontreal.qc.ca/uploads/tx_asssmpublications/978-2-89673-119-0.pdf

82 Agence de la santé et des services sociaux de la Mauricie et du Centre du Québec (May 2012). *Rapport du directeur de santé publique sur les inégalités sociales de santé en Mauricie et au Centre-du-Québec*. Retrieved from: http://www.agencesss04.qc.ca/images/images/santepublique/direction/RapportDSP/rapportdsp_2012_finale_version_web.pdf

83 Agence de la santé et des services sociaux de la Capitale-Nationale (2012). *Rapport du directeur régional de santé publique sur les inégalités sociales de santé*. Retrieved from: http://www.dspq.qc.ca/documents/RapoportISS_versionintegrale.pdf

84 Public Health Agency of Canada (PHAC) (2008). *The Chief Public Health Officer's Report on The State of Public Health in Canada, 2008*. Retrieved from: http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2008/fr-rc/index-eng.php

85 Parliament of Canada, Senate Committees. *Reports of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology*, *2008*. Retrieved from: http://www.parl.gc.ca/SenCommitteeBusiness/CommitteeReports.aspx?parl=39&ses=2&Language=E&comm_id=605

86 Government of Canada (1985). Canada Health Act R.S.C., c. C-6. Retrieved from: http://laws-lois.justice.gc.ca/PDF/C-6.pdf

87 Service Canada. Retrieved from: http://www.servicecanada.gc.ca/eng/sc/ei/index.shtml

88 Service Canada. Retrieved from: http://www.servicecanada.gc.ca/eng/services/pensions/oas/index.shtml

89 Service Canada. Retrieved from: http://www.servicecanada.gc.ca/eng/about/scpublications.shtml

90 Cutler, D.M. & Lleras-Muney, A. (2006). *Education and Health: Evaluating Theories and Evidence*. NBER Working Paper N°. 12352. JEL No. I1, I2.

91 WHO Commission on Social Determinants of Health (2009). *Closing the gap in a generation: Health equity through action on the social determinants of health. Final report: Executive Summary.*

92 Wood, D. (2003). Effect of Child and Family Poverty on Child Health in the United States. *Pediatrics, 112* (3), 707-11.

93 Lopez, A., Moleux, M., Schaetze, F. & Scotton, C. (2011). *Les inégalités sociales de santé dans l'enfance : santé physique, santé morale, conditions de vie et développement de l'enfant*. Rapport, Inspection générale des affaires sociales (IGAS), France.Government of Québec (2007). *Troisième rapport national sur l'état de santé de la population du Québec : Riches de tous nos enfants : la pauvreté et ses répercussions sur la santé des jeunes de moins de 18 ans.* Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2007/07-228-05.pdf

94 http://www.rqap.gouv.qc.ca/Index_en.asp

95 Website of the *Québec Pension Plan*: http://www.rrq.gouv.qc.ca/en/accueil/Pages/accueil.aspx

96 http://www.rrq.gouv.qc.ca/en/programmes/soutien_enfants/Pages/soutien_enfants.aspx

97 http://www.rrq.gouv.qc.ca/en/services/formulaires/soutien_aux_enfants/supplement_enfant_handicape/Pages/lpf-825.aspx

98 http://www4.gouv.qc.ca/EN/Portail/Citoyens/Evenements/DevenirParent/Pages/progr_plac_contr_redt.aspx

99 Ministère de la Famille et des Aînés (2007). *Meeting Early Childhood Needs: Québec's Educational Program for Childcare Services*. Retrieved from: http://www.mfa.gouv.qc.ca/fr/publication/Documents/programme_educatif_en.pdf

100 Bill n°23: An Act to amend the Education Act concerning certain educational services for four-year-old students from underprivileged backgrounds. Retrieved from: http://www.assnat.qc.ca/en/travaux-parlementaires/projets-loi/projet-loi-23-40-1.html

101 Government of Québec, Ministère de la Santé et des Services sociaux (2004). *Les services intégrés en périnatalité et pour la petite enfance*. *Cadre de référence*. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2004/04-836-02W.pdf

102 http://www.mfa.gouv.qc.ca/fr/Famille/travail-famille/programme/Pages/milieux-travail.aspx

103 http://www.mfa.gouv.qc.ca/fr/Famille/travail-famille/norme/Pages/index.aspx

104 http://www.education.gov.uk/vocabularies/educationtermsandtags/1418

105 Melhuish, E., Belsky, J. & Barnes, J. (2010). *Le programme Sure Start et son évaluation en Angleterre*. Encyclopédie sur le développement des jeunes enfants. Retrieved from: http://www.enfant-encyclopedie.com/documents/Melhuish-Belsky-BarnesFRxp1.pdf

106 Johnson, S. (2011). *Impact of social science on policy: Sure Start case study. Report to Economic and Social Research Council (ESRC).* Retrieved from: http://www.esrc.ac.uk/_images/Sure_Start_final_report_tcm8-20116.pdf

107 UNICEF, Innocenti Research Centre (2007). *Child poverty in perspective: An overview of child well-being in rich countries. Report card 7*. Florence. Retrieved from: http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf

108 Paquet, G. (2009). Atelier 'Petite enfance'. Les inégalités sociales à la petite enfance : comment réduire leur répercussions à l'âge adulte? *Éducation Santé*, *no 245*, May 2009.

109 http://www.mels.gouv.qc.ca/en/home/

110 Government of Québec, Ministère de l'Éducation, du Loisir et du Sport (2009). *I care about school! All together for student success*. Retrieved from: http://www.mels.gouv.qc.ca/en/references/publications/results/detail/article/i-care-about-school-all-together-for-student-success-1/

111 Government of Québec, Ministère de l'éducation (2002). *Agir autrement pour la réussite des élèves du secondaire en milieu défavorisé*. Stratégie d'intervention pour les écoles secondaires. Retrieved from: http://www.fse.qc.net/fileadmin/user_upload/documents/VP/SIAA/2_%E2%80%93_Agir_autrement_pour_la_reussite_des_eleves_en_m.pdf

112 See the evaluation report of the *Agir autrement* strategy. Retieved from: http://www.gres-umontreal.ca/download/feuillet_fr.pdf

113 Website of the École en santé approach: http://ecoleensante.inspq.qc.ca

114 Website for Aide financière aux études : http://www.afe.gouv.qc.ca/en/index.asp http://www.afe.gouv.qc.ca/fr/autresProgrammes/etudesTravail.asp

115 http://www.mels.gouv.qc.ca/

116 http://www.afe.gouv.qc.ca/en/autresProgrammes/etudesTravail.asp

117 Department of Education and Science (2005). *Delivering Equality of Opportunity In School. An Action Plan for Educational Inclusion*. Ireland. Retrieved from: http://www.education.ie/en/Publications/Policy-Reports/deis_action_plan_on_educational_inclusion.pdf

118 Department of Education and Skills (2011*).OECD Project Overcoming School Failure: Policies that Work*. National Report: Ireland. Retrieved from: http://www.oecd.org/ireland/49624509.pdf

119 Norwegian Ministry of Education and Research (2006*). Early Intervention for Lifelong Learning*. Summary of Report Nº. 16 (2006-2007) to the Storting. Retrieved from: http://www.regjeringen.no/upload/KD/Vedlegg/St.meld.nr.16/Sammendrag_fransk%20oversettelse_2802.pdf

120 Government of Québec, Ministère de l'Éducation, du Loisir et du Sport (2009*). I care about school! All together for student success*.

121 Information on the social assistance program: http://www4.gouv.qc.ca/EN/Portail/Citoyens/Evenements/deces/Pages/programme-aide-sociale.aspx

122 Information on the socia solidarity program: http://www4.gouv.qc.ca/EN/Portail/Citoyens/Evenements/deces/Pages/programme-solidarite-sociale.aspx

123 Information on the Youth Alternative program: http://emploiquebec.gouv.qc.ca/en/citizens/obtaining-financial-assistance/assistance-for-individuals-under-age-25/

124 Website web of the Québec Pension Plan: http://www.rrq.gouv.qc.ca/en/accueil/Pages/accueil.aspx

125 *Stratégie de mobilisation tous pour l'emploi*. Retrieved from: http://www.mess.gouv.qc.ca/grands-dossiers/tous_pour_emploi.asp

126 Information on the employment pact: http://www.finances.gouv.qc.ca/documents/Autres/en/AUTEN_update2009-sheet2.pdf

127 Information on employment assistance: http://emploiquebec.gouv.qc.ca/en/citizens/finding-a-job/employment-assistance-services/

128 Information on wage subsidies :http://emploiquebec.gouv.qc.ca/en/citizens/starting-a-new-job/employment-integration-programs/wage-subsidy/

129 Information on skills training: http://emploiquebec.gouv.qc.ca/en/citizens/developing-your-skills-and-having-them-recognized/training/

130 Information on the work premium: http://www.revenuquebec.ca/en/citoyen/credits/prime_travail/default.aspx

131 Information on the Stratégie québécoise de l'entreprenariat: http://www.mdeie.gouv.qc.ca/objectifs/informer/entrepreneuriat/page/strategies-14248/?tx_igaffichagepages_pi1%5Bmode%5D=single&tx_igaffichagepages_pi1%5BbackPid%5D=72&tx_igaffichagepages_pi1%5BcurrentCat%5D=&cHash=34b6652e66969320386c9e64ccc30a56

132 Information on the income support program for older workers: http://emploiquebec.gouv.qc.ca/fileadmin/fichiers/pdf/Citoyens/sr_dep_travailleurs_ages_en.pdf

133 Information on the employment integration program for immigrants and visible minorities (PRIME): http://emploiquebec.gouv.qc.ca/en/citizens/starting-a-new-job/employment-integration-programs/employment-integration-program-for-immigrants-and-visible-minorities-priime/

[134] According to the comparative tables available on the website of the European Commission. Retrieved from: http://ec.europa.eu/social/main.jsp?langId=en&catId=815.

[135] Kangas, O. (2010). One hundred years of money, welfare and death: mortality, economic growth and the development of the welfare state in 17 OECD countries. *International Journal of Social Welfare*, *19,* S42-S59.

[136] Ferrarini, T. & Norström T. (2010). Family policy, economic development and infant mortality: a longitudinal comparative analysis. *International Journal of Social Welfare*. *19,* S89–S102.

[137] Royal Norwegian Ministry of Labour and Social Inclusion. *Work, Welfare and Inclusion.* Retrieved from: http://www.regjeringen.no/Upload/AID/vedlegg/stmeld_9_2006_english.pdf

[138] New Zealand Government. *Labour Market and Employment Strategy: Better Work, Working Better*. Retrieved from: http://www.dol.govt.nz/PDFs/better-work.pdf

[139] Scottish Government and Health Action Partnership International (January 2012). *Working for Equity in Health: The role of work, worklessness and social protection in health inequalities. Context, situation analysis and evidence review*.

[140] White, D. (Lead researcher) (2011). *Vers une politique saine d'activation : L'impact sur la santé et bien -être des pre d'aide sociale de l'intégration des services de sécurité du revenu et d'employabilité*. Université de Montréal.

[141] Government of Québec, Ministère de l'Emploi et de la Solidarité sociale (2010). *2010-2015 Government Action Plan for Solidarity and Social Inclusion: Québec's Combat Against Poverty*. Retrieved from: http://www.mess.gouv.qc.ca/grands-dossiers/index_en.asp

[142] Government of Québec, Ministère de la Santé et des Services sociaux (2014). *Politique nationale de lutte à l'itinérance : ensemble pour éviter la rue et en sortir*. Retrieved from: http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/4b1768b3f849519c852568fd0061480d/a8196cc9e89d272585257c8c00631337?OpenDocument

[143] Government of Québec, Ministère de la Santé et des Services sociaux (2009). *Pour leur redonner… la dignité, la confiance, un toit, la santé, l'espoir, un avenir*. *Plan d'action interministériel en itinérance 2010-2013*. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2009/09-846-01.pdf

[144] http://www.mess.gouv.qc.ca/sacais/action-communautaire/politique-reconnaissance-soutien_en.asp

[145] Information on Legal Aid: http://www.justice.gouv.qc.ca/english/sujets/glossaire/aide-jur-a.htm

[146] Information on the Youth Action Strategy 2009-2014: http://www.jeunes.gouv.qc.ca/documentation/publications/documents/strategie-action-jeunesse-2009-2014_en.pdf

[147] Information on the Action Strategy for the Elderly: http://www.budget.finances.gouv.qc.ca/budget/2007-2008/en/pdf/Aines.pdf

[148] Québec Pay Equity Act. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/E_12_001/E12_001_A.html

[149] Government of Québec, Secrétariat à la condition féminine du ministère de la Culture, des Communications et de la Condition féminine (2011). *Pour que l'égalité de droit devienne une égalité de fait*. *Plan d'action gouvernemental pour l'égalité entre les femmes et les hommes 2011-2015*. Retrieved from: http://www.scf.gouv.qc.ca/fileadmin/publications/politique/Plan_d_action__complet__2011-06-13.pdf

[150] Diversity: An Added Value: Government Policy to Promote Participation of all in Québec's Development (2008). Retrieved from: http://www.micc.gouv.qc.ca/publications/fr/dossiers/PolitiqueFavoriserParticipation_Synthese_en.pdf

[151] An Act to Secure Hanicapped Persons in the Exercise of Their Rights With a View to Achieving Social, School and Workplace Integration. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/E_20_1/E20_1_A.html

[152] Information on the *Equals in Every Respect* program: http://www.ophq.gouv.qc.ca/partenaires/politique-a-part-entiere.html

[153] Social Inclusion Unit, Department of the Prime Minister and Cabinet (2009). *A Stronger, Fairer Australia*. Australian Government. Retrieved from: http://www.socialinclusion.gov.au/sites/www.socialinclusion.gov.au/files/publications/pdf/brochure_stronger_fairer_australia.pdf

[154] Government of Ireland (2007). *National Action Plan for Social Inclusion 2007-2016*. Dublin, Ireland. Retrieved from: http://www.socialinclusion.ie/nationalactionplan2007.html

155 An Act Respecting Labour Standards. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/N_1_1/N1_1.html

156 http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C_27/C27_A.html

157 An Act Respecting Industrial Accidents and Occupational Diseases. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/A_3_001/A3_001_A.html

158 An Act Respecting Occupational Health and Safety. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_2_1/S2_1_A.html

159 Act Relating to Working Environment. Norway. Retrieved from: http://www.arbeidstilsynet.no/binfil/download2.php?tid=92156

160 Sustainable Development Act. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/D_8_1_1/D8_1_1_A.html

161 Information on Québec's *Government Sustainable Development Strategy 2008-2013*. Retrieved from: http://www.mddep.gouv.qc.ca/developpement/strategie_gouvernementale/index_en.htm

162 Profession Banlieue (2009). *Développement durable et politique de la ville. Pour un enrichissement réciproque*, DAC Communication.

163 An Act Respecting Land Use Planning and Development. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/A_19_1/A19_1_A.html

164 Government of Québec, Ministère des Affaires municipales, des Régions et de l'Occupation du territoire, 2011. *Nos territoires : y habiter et en vivre! Stratégie pour assurer l'occupation et la vitalité des territoires 2011-2016*. Retrieved from: http://www.mamrot.gouv.qc.ca/pub/occupation_territoire/strategie_occupation.pdf

165 An Act to Ensure the Occupancy and Vitality of Territories. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FO_1_3%2FO1_3_A.htm

166 Information on *Revitalisation urbaine intégrée* on the Villes et Villages en santé website: http://www.rqvvs.qc.ca/fr/membres-et-projets/projet/revitalisation-urbaine-integree

167 Information on the *Socially Integrative CityProgram:* http://www.stadtentwicklung.berlin.de/soziale_stadt/index_en.shtml

168 Matinez, Z.M. & Ciocoletto, A. (2009). *Catalonian Neighbourhood Development Law: the Gender Perspective as a Planning Tool*. The 4th International Conference of the International Forum on Urbanism (IFoU) 2009, The New Urban Question – Urbanism beyond Neo-Liberalism, Amsterdam/Delft.

169 Sierra, I. (2002). *The Health in Neighbourhood Strategy : Integrated actions in areas with special social and health need*. Retrieved from: http://www.instituteofhealthequity.org/projects/the-health-in-neighborhoods-strategy

170 *Plan stratégique de la Société d'habitation du Québec (SHQ) 2011-2016*. Retrieved from: http://www.habitation.gouv.qc.ca/fileadmin/internet/publications/0000021415.pdf

171 Informations on the SHQ's programs: http://www.habitation.gouv.qc.ca/english.html

172 Information on the SHQ's *Low-rental Housing Program*. Retrieved from: http://www4.gouv.qc.ca/EN/portail/citoyens/evenements/aines/pages/habitation-loyer-modique.aspx

173 Government of Québec, MSSS & SHQ (2007). *Cadre de référence sur le soutien communautaire en logement social – Une action intersectorielle des réseaux de la santé et des services sociaux et de l'habitation*. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2007/07-845-01.pdf

174 Municipal Powers Act. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/C_47_1/C47_1_A.html

175 Welsh Assembly Government, Minister of Housing and Regeneration (2010). *Improving Lives and Communities. Homes in Wales*. Retrieved from: http://wales.gov.uk/docs/desh/publications/100421housingstrategyen.pdf

176 Welsh Assembly Government, Minister of Housing and Regeneration (2008). *Housing Quality Standard*. *Revised Guidance for Social Landlords on Interpretation and Achievement of the Welsh Housing Quality Standard*. Retrieved from: http://wales.gov.uk/docs/desh/publications/091207housingwhqsguide.pdf

177 Welsh Assembly Government, Wales Audit Office (2012). *Social Landlords' Performance in Achieving the Welsh Housing Quality Standard* (Revised). *Evaluation Report*. Retrieved from: http://wales.gov.uk/docs/desh/publications/121011housingwhqsreviseden.pdf

[178] Information on the *Programme d'aide gouvernementale au transport adapté*: http://www.mtq.gouv.qc.ca/portal/page/portal/grand_public_en/transport_collectif/transport_adapte

[179] *National Strategy for Sustainable Mobility*. Retrieved from: http://www.mobilitedurable.gouv.qc.ca/portal/page/portal/grand_public_en/transport_collectif/strategie_nationale_mobilite_durable

[180] Information on the Québec Public Transit Policy: http://www.mtq.gouv.qc.ca/portal/page/portal/Librairie/Publications/en/transport_collectif/transit_policy_nov06.pdf

[181] Government of Québec, Ministère des transports (2008). *Bicycle Policy: From Fun to Functional: Cycling – A Mode of Transportation in its Own Right*. Retrieved from: http://www.mtq.gouv.qc.ca/portal/page/portal/Librairie/Publications/fr/v%E9lo/velo_politique2008.pdf

[182] Dancourt, F. (2008). *Gouvernance urbaine à Bogotà. Fiche synthèse*. Convention Urbanistes du Monde – Master STU ScPo, Fondation Léopold Mayer.

[183] http://www.rivm.nl/bibliotheek/rapporten/270626001.pdf (p. 77)

[184] Janßen C., Sauter, S.,Kowalski, C.(2012). The influence of social determinants on the use of prevention and heatlh promotion services: Results of a systematic literature review. *Psychosoc Med*. 2012;9:Doc07. doi: 10.3205/psm000085. Epub 2012 Oct 25.

[185] Government of Québec, MSSS (2006). *Plan d'action gouvernemental de promotion des saines habitudes de vie et de prévention des problèmes reliés au poids 2006-2012 - Investir pour l'avenir*. http://msssa4.msss.gouv.qc.ca/fr/document/publication.nsf/961885cb24e4e9fd85256b1e00641a29/92885999c9ad58748525720d00653c6b?opendocument

[186] An Act to Estabish the Sports and Physical Activity Development Fund. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/F_4_003/F4_003_A.html

[187] Kino-Québec website: http://www.kino-quebec.qc.ca/qui.asp

[188] Information on the *Programme éducatif en services de garde*: http://www.mfa.gouv.qc.ca/fr/services-de-garde/cpe-garderies/programme-educatif/programme-educatif/Pages/index.aspx

[189] Buzeti, T. & Zakotnik, J. M. (2008). *Investment for Health and Development in Slovenia. Programme MURA*. Centre for Health and Development Murska Sobota. Retreived from: http://www.eu2008.si/en/News_and_Documents/Fact/March/0310_publikacija.pdf
Information on the *Programme MURA* in Slovenia: http://data.euro.who.int/Equity/hidb/Resources/Details.aspx?id=9

[190] Nordic Council of Ministers (2006). *A better life through diet and physical activity Nordic Plan of Action on better health and quality of life through diet and physical activity*. Copenhague, Danemark. Retrieved from: http://www.norden.org/en/publications/publikationer/2006-746/at_download/publicationfile

[191] Information on the North Karelia project: http://www.inspq.qc.ca/pdf/publications/1564_CarelieNordMouvSocSainesHabitudesVie.pdf

[192] Norwegian Ministry of Health and Care Services (2007). *Recipe for a Healthier Diet. Norwegian Action Plan on Nutrition 2007-2011*. Retrieved from: http://www.regjeringen.no/upload/HOD/Dokumenter%20FHA/SEM/Kostholdsplanen/IS-0238%20kortversjon%20eng.pdf

[193] Government of Québec, MSSS, 2008. *Cadre de référence en matière de sécurité alimentaire*. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2008/08-208-01.pdf

[194] Food Poverty Eradication Bill: http://www.publications.parliament.uk/pa/cm200102/cmbills/069/2002069.pdf

[195] Bergeron, P. & Reyburn, S. (2010). *L'impact de l'environnement bâti sur l'activité physique, l'alimentation et le poids*. Collection Politiques publiques et santé. INSPQ: Québec. Retrieved from: http://www.inspq.qc.ca/pdf/publications/1108_ImpactEnvironBati.pdf

[196] Tobacco Act. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/T_0_01/T0_01_A.html

[197] Government of Québec, MSSS (2010). *Le Québec respire mieux*. *Plan québécois de prévention du tabagisme chez les jeunes 2010-2015*. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2010/10-006-06F.pdf

198 Government of Québec. *Plan d'action interministériel en toxicomanie 2006-2011. Unis dans l'action*. Retrieved from: http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2005/05-804-01.pdf

199 Commonwealth of Australia, Ministerial Council on Drug Strategy (2011). *National Drug Strategy 2010-2015. A framework for action on alcohol, tobacco and other drugs*. Retrieved from: http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/DB4076D49F13309FCA257854007BAF30/$File/nds2015.pdf

200 Government of New Zealand, Ministry of Health. *Manatu Hauora: Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11–2015/16*. Retrieved from: http://www.health.govt.nz/publication/preventing-and-minimising-gambling-harm-six-year-strategic-plan-2010-11-2015-16

201 WHO (2010). *Review of physical activity promotion policy development and legislation in European Union Member States*: *Project on monitoring progress on improving nutrition and physical activity and preventing obesity in the European Union, Report no. 10*. Retrieved from: http://www.euro.who.int/__data/assets/pdf_file/0015/146220/e95150.pdf

202 Frenk, J. (1992). The concept and measurement of accessibility. In Pan American Health Organization (Eds.), *Health Services Research: An Anthology*, *17*, 858-864. Washington.

203 Penchansky, R., Thomas, W.J. (1981). The Concept of Access: Definition and Relationship to Consumer Satisfaction. *Medical Care*, *19*(2), 127-140.

204 Mackenbach, J. P., Kunst, A. E. (2012). Evidence for strategies to reduce socioeconomic inequalities in health in Europe. In Figueras, J., McKee, M. *Health Systems, Health, Wealth and Societal Well-being* (Chapter 7, pp.153-174). McGraw Hill & Open University Press.

205 RAMQ website: http://www.ramq.gouv.qc.ca/en/Pages/home.aspx

206 Hospital Insurance Act. Québec. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FA_28%2FA28_A.htm

207 Information on the Public Prescription Drug Insurance Plan: http://www.ramq.gouv.qc.ca/en/citizens/prescription-drug-insurance/Pages/prescription-drug-insurance.aspx

208 Lang T. (2008). *Inégalités sociales de santé et de soins. Le couple inégalités par omission, inégalités par construction*. Presentation given on November 17, 2008 at the Rencontre francophone internationale sur les ISS des Journées annuelles de santé publique. http://jasp.inspq.qc.ca/Data/Sites/1/SharedFiles/presentations/2008/13_35_Thierry_Lang.pdf

209 European Commission (2008). *Quality and equality of access to healthcare*. Bruxelles: European Health Management Association (EHMA).

210 Widström, E. (October 2006). *Extension of publicly funded dental care to all*. *Health Policy Monitor*. Retrieved from: http://www.hpm.org/survey/fi/a8/2

211 Lien Nguyen (2008). *Dental Service Utilization, Dental Health Production and Equity in Dental Care: the Finnish Experience*. *STAKES, Research Report 173*. Helsinki, Finland.

212 Government of Québec. An Act Respecting Health and Social Services. Retrieved from: http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=%2F%2FS_4_2%2FS4_2_A.htm

213 Information on the Centres de santé et de services sociaux (CSSS): http://www.msss.gouv.qc.ca/reseau/rls/

214 CSBE website: http://www.csbe.gouv.qc.ca/en/home.html

215 Government of Québec, Le Commissaire à la santé et au bien-être (2009). *Rapport d'appréciation de la performance du système de santé et de services sociaux. Construire sur les bases d'une première ligne de soins renouvelée : recommandations, enjeux et implications* (136 pp).

216 Government of Québec, Le Commissaire à la santé et au bien-être (2011). *Rapport d'appréciation de la performance du système de santé et de services sociaux. Pour une vision à long terme en périnatalité et en petite enfance : enjeux et recommandations* (302 pp).

217 Government of Québec, Le Commissaire à la santé et au bien-être (2012). *Rapport d'appréciation de la performance du système de santé et de services sociaux. Pour plus d'équité et de résultats en santé mentale au Québec* (179 pp).

218 UK Government, Department of Health (2001). *National Service Framework for Older People*. Retrieved from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4071283.pdf

[219] Manthorpe, J. (2007). Accessing Services and Support, In Gates, B. (ed.), *Learning Disabilities: Toward Inclusion* (pp. 85-104). Edinburgh: Churchill Livingstone.

[220] Davis, H. & Ritters, K. (2009). *LinkAge Plus National Evaluation: End of Project Report*. *Research Report Nº 572.* Department of Work and Pensions, UK Government. Retrieved from: http://research.dwp.gov.uk/asd/asd5/rports2009-2010/rrep572.pdf

[221] UK Government, Personal Social Services Research Unit for Department of Health (2010). *National Evaluation of Partnerships for Older People Projects: final report.* Retrieved from: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111240

[222] World Health Organization / World Organization of Family Doctors (2008). *Integrating mental health into primary care: a global perspective.* Retrieved from: http://www.who.int/mental_health/policy/services/integratingmhintoprimarycare/en/index.html

[223] UK Government, Department of Health. *No Health without mental health : a cross-government mental health outcomes strategy for people of all ages. Retrieved from:* http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766

[224] UK Government, Department of Health (2011). *No Health Without Mental Health: A Cross-Government Mental Health Outcomes strategy for people of all ages. Analysis of the Impact on Equality (AIE)*. Retrieved from: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123989.pdf

[225] Government of Québec, Ministère de l'Éducation (2002). *Learning throughout life: Government policy on adult education and continuing education and training*. Retrieved from: http://www.mels.gouv.qc.ca/fileadmin/site_web/documents/publications/anterieur/politique_a.pdf

[226] Information on the *MiMi-With Migrants for Migrants* program in Germany: http://data.euro.who.int/Equity/hidb/Resources/Details.aspx?id=2

[227] Salman, R., Weyers, S. (2010) Germany: With Migrants for Migrants. In *Poverty and social exclusion in the European Region: Health systems respond.* Copenhagen: WHO Regional Office for Europe.

[228] *With Migrants for Migrants - Intercultural Health in Germany*. DETERMINE EU Consortium for action on the socio-economic determinants of health (2009) (retrieved December 6, 2009).

[229] Roy, M-R., Fréchet, G., Savard, F. (2008). Le Québec, à l'avant-garde de la lutte contre la pauvreté au Canada. *Options politiques, septembre 2008*. Retrieved from: http://www.irpp.org/fr/options-politiques/travail-et-pauvrete-au-canada/le-quebec-a-lavant-garde-de-la-lutte-contre-la-pauvrete-au-canada-fr-ca/

[230] Raynault, Marie-France (2009). Les inégalités sociales, un choix de société? *Revue Développement Social, Volume 10*, Nº. 2. Retrieved from: http://www.revueds.ca/les-inegalites-sociales-un-choix-de-societe.aspx

[231] World Health Organization (2008). *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. *Final Report of the Commission on Social Determinants of Health*. Geneva. Retrieved from: http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf

[232] Pampalon, R. et al. (2013). Une stratégie et des indicateurs pour la surveillance des inégalités sociales de santé au Québec. Institut national de santé publique du Québec (81 pp). Retrieved from: http://www.inspq.qc.ca/pdf/publications/1698_StratIndicSurvISSQc.pdf

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