Policy Approaches to Reducing Health Inequalities

March 2016

Introduction

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

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

Health inequalities[1] are understood to be unfair and systematic differences in health among and between social groups – differences which need to be addressed through action. These result from social and political circumstances and are therefore potentially avoidable. To address these inequalities, the relationships between the determinants of health and the health of the population have been brought to the fore so as to direct political action, which can include programmatic intervention at several levels. Despite repeated calls for more action at the structural level *and* despite political recognition of the importance of this type of action for reducing health inequalities (Popay, Whitehead, & Hunter, 2010), in reality, for various ideological, historical or practical reasons (Baum, 2011; Baum & Fisher, 2014), policies have more generally aimed at promoting healthy lifestyles and behaviour (e.g., the tax credit promoting physical activity for children in families). This tendency to recognize the need to act on the more structural determinants of health inequalities but to instead develop interventions targeting the more behavioural determinants of health is sometimes called "lifestyle drift." This has heightened the individualization of responsibility for health (Baum & Fisher, 2014; Baum, 2011) and in some cases, limited the reduction of inequalities or even led to their intensification (Scott-Samuel & Smith, 2015). There is also a preponderance of policies targeting individuals and communities that are already disadvantaged rather than an attempt to reduce inequalities across the gradient. Such policies limit action that effectively reduces health inequalities throughout the population (Popay et al., 2010).

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

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

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