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Policy Avenues: Interventions to Reduce Social Inequalities in Health

REPORT

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Foreword

The Institut national de santé publique du Québec (INSPQ) is a public health expertise and reference centre in Québec. Its mission is to support Québec's minister of health and social services, regional public health authorities and institutions in the exercise of their responsibilities, by making available its expertise and its specialized laboratory and testing services.

More specifically, one of the INSPQ's mandates is to assess the positive and negative impacts of public measures or policies on the health of the Québec population on the basis of the best available data. The problem of social inequalities in health has been identified by the Ministère de la Santé et des Services sociaux (MSSS) [department of health and social services], as a priority topic for the INSPQ's Équipe politiques publiques [public policy team] whose work is focused on analyzing the relationship between public policies and the social determinants of health.

It is, therefore, in connection with this support function that the Direction générale de santé publique [public health branch] of the Ministère de la Santé et des Services sociaux du Québec has mandated the INSPQ to produce a summary document reviewing government interventions aimed at reducing social inequalities in health (SIH) for purposes of decision support.

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Highlights

Various social factors, such as education, income, work, living environment, housing, lifestyle 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). These inequalities are not inevitable and could be reduced, according to the World Health Organization (WHO). 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 an array 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 other countries have instead developed a national public health policy that explicitly targets the reduction of SIH, or addresses 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 implemented in conjunction with interventions 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 enhance their accessibility.

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.

Introduction

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. Although Québec functions as a province within a federal system, by examining the policies of countries presented in the second section of this document, Québec may draw inspiration that can guide efforts to pursue or strengthen its interventions targeting SIH. 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, municipal or local levels, or from still other sources, such as the community or private sectors.

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.

This document consists of four sections. The first section provides some background on social inequalities in health by presenting definitions and a conceptual framework of this problem, in addition to recalling some historical factors. This section also includes a discussion of the scope of SIH in Québec and focuses on various intersectoral approaches as well as the socio-political context

of this issue. The second section presents an overview of comprehensive governmental approaches to reducing SIH implemented in the six countries considered as pioneers in this area. Next, the third section discusses the Québec context and the various initiatives developed there which would pave the way for the possibility of a more concerted effort on the part of the government to reduce SIH. Finally, the fourth section presents an overview of approaches to SIH reduction that target one or more of the social determinants of health upstream, which is more consistent with what is observable in Québec. Several sectoral or intersectoral interventions that target health determinants as a means of combating SIH in Québec or elsewhere are described for five sectors, namely those of early childhood and education; employment, income and social solidarity; the environment and land use planning; lifestyle; and the health care and health services systems. Finally, the document concludes with a discussion of the main challenges and limitations associated with combating SIH as well as those associated with policy avenues that can support this social health objective.

1 Social inequalities in health: background

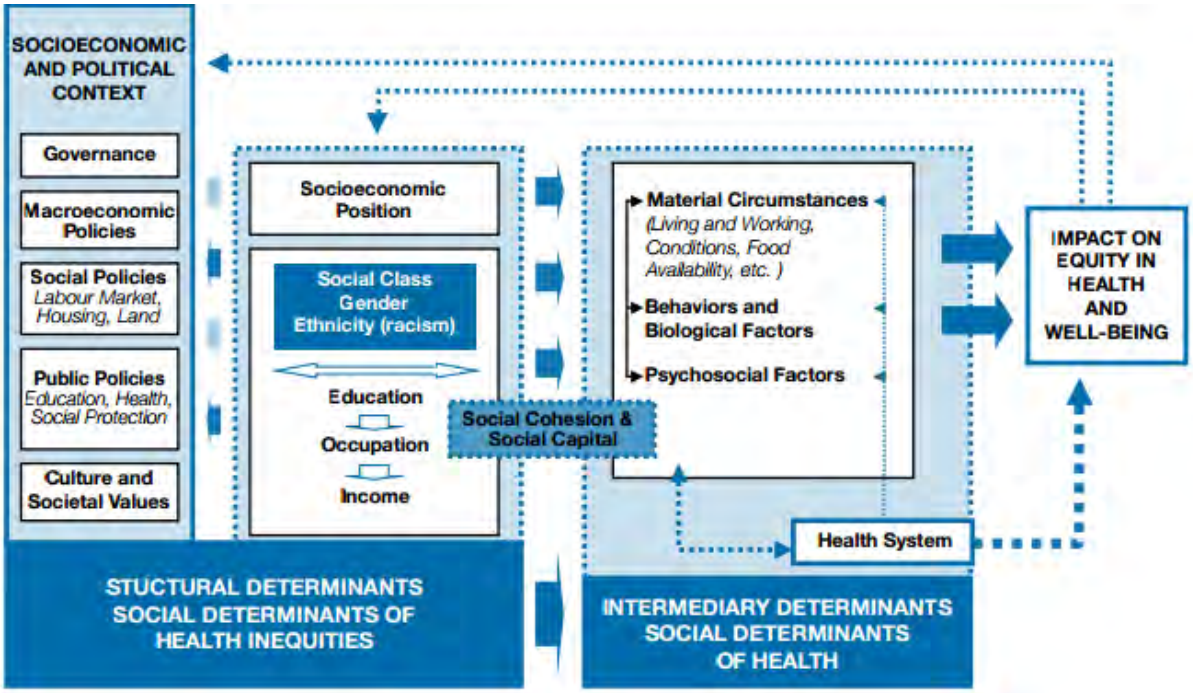
1.1 Social determinants of health, SIH and the social health gradient

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 (6). Many factors, such as education, work, income, living environment, housing, lifestyle 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. They refer to all relationships between health and membership in a social category.[1] This synthesis focuses on social inequalities in health which, on the one hand, are more specific than the social inequalities from which they arise and which, on the other hand, differ from health inequalities which refer to the unequal distribution of health status tied to genetic and physiological factors unrelated to questions of equity and social justice.[2] Because these inequalities are avoidable, the WHO considers these gaps to be unfair(10). Unequal power dynamics and exclusion, as well as certain social policies, norms and practices engender these social and health disparities. The need to take SIH into account when considering government intervention, at the very least to avoid worsening the situation, is acknowledged by experts.

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, known as intermediate health determinants, that have an impact on SIH (see Figure 1).

Figure 1 Conceptual framework of the social determinants of health



Source: World Health Organization (2011). p. 7[3]

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.**

These social inequalities in health also tend to increase over the life course. The reason, according to the "life course" approach, is that health is not only the result of current living conditions, but also of past living conditions. This approach considers not only the biological, psychological and social dimensions of individuals, but also their temporal trajectories.[4] This perspective helps explain why the determinants of health affect individuals differently depending on their different stages. Thus, the standard of living of a child's family influences the number of years he or she can expect to live in good health. However, this approach demonstrates that although individuals in disadvantaged socioeconomic groups are more likely to suffer from diseases, vulnerability or social exclusion throughout life, these determinants of health may also be corrected or modified.[5]

1.2 Interventions to reduce SIH

Interest in social inequalities in health is not recent, the first documents addressing this issue having been published in Europe the 19th century. In 1842 in England, Edward Chadwick identified the link between life expectancy and the drinking water supply in various districts. In 1848 in Germany, Rudolf Virchow recommended education, freedom and prosperity to counter an outbreak of typhus in Upper Silesia. At the same time, Friedrich Engels was analyzing the health of workers in relation to the development of industrial capitalism in England. During this period, social struggles were taking place throughout Europe and these became the engine of social progress. Within this context, the

link between health and living conditions was increasingly being documented. Later, medical developments beginning in the 1950s suggested that health inequalities would disappear with universal access to medical care. The development of public health knowledge called into question this medical illusion since research into the causes of chronic diseases and the variation in mortality rates between social groups indicated the existence of “social” causes or social determinants of health[6] over which medicine was powerless.

In recent years, many international organizations, including the WHO, the World Bank, Unicef, the Pan American Health Organization and the United Nations have made health inequalities a priority for international action.[7] In 1986, the Ottawa Charter for Health Promotion committed its signatories “to respond to the health gap within and between societies and to tackle the inequities in health produced by the rules and practices of these societies.”[8] In 2005 in Europe, the member countries of the European Union established as a common goal the reduction of health inequalities through the coordination of their different social inclusion policies. The following year, health equity was identified by the European Council as one of the principal values common to European health systems, before making this an action priority of the European health strategy for 2008-2013.[9] Many governments have long recognized the existence of SIH, measured their progress and reflected on the best ways to counter them. Given the effects of the recent global economic crisis, this problem has emerged as a priority, and action is increasingly being urged by international organizations such as the World Health Organization’s Commission on Social Determinants of Health.[10] WHO/Europe, its member states and partners are organizing their efforts around the Health 2020 strategy which "will build partnerships for action and capture promising innovations to tackle the complex determinants and drivers of health and health equity."[11]

Two American sociologists, Link and Phelan, began developing in 1995,[12] a "theory of fundamental causes" to try to explain why inequalities in health and mortality have persisted at very similar rates since at least the beginning of the 19th century, and this is despite the eradication in the wealthiest countries of several infectious diseases that more severely affected disadvantaged people due to their inadequate sanitation and housing conditions. Health inequalities now reflect the new causes of mortality including cardiovascular disease and cancers and are compounded by risk factors such as physical inactivity, smoking and eating habits which are associated with socioeconomic status. Moreover, inequalities seem to persist despite the strategies many countries have adopted for reducing these risk factors. These researchers explain that socioeconomic status is associated with access to resources such as money, knowledge, prestige, power and a social network and that access to these resources has a protective effect on health. Consequently, the root causes of health inequalities — namely, difficult access to these resources, affect health regardless of diseases or risk profiles.[13]

Relying on this theory, a recent study analyzing the causes of mortality between 1961 and 1999 in Scotland demonstrates that a clear socioeconomic gradient exists for avoidable causes of mortality, but not for unavoidable causes of mortality.[14] Thus, inequality in mortality increases when its causes can be prevented. These authors conclude that a real reduction of inequalities in mortality requires broader action aimed at reducing social inequalities, including differences in income, wealth and power throughout the whole of society. The authors also argue that the current Scottish approach to reducing inequalities by addressing proximal determinants such as smoking has done little to reduce these gaps.

Link and Phelan also arrive at these conclusions when they address the issue of political interventions(12). To reduce SIH, their theory of fundamental causes calls for interventions targeting access to resources rather than individual approaches targeting risk factors. The approach targeting

risk factors, although it often leads to an overall improvement in the health status of a population, often produces a rise in SIH because it is tied to an individual's access to resources. This is why these sociologists suggest that the primary focus should be on the reduction of inequalities in access to resources through measures that promote social security, income support, access to employment, social housing, parental leave, access to education, etc. These authors also stress the importance of prioritizing interventions that do not involve behavioural changes or require that individuals make use of resources.

Nevertheless, government intervention to reduce SIH is neither simple nor unambiguous, and necessarily involves an array of interventions. Taking into account the broader socio-political context surrounding social inequalities is essential to guiding interventions, as will be argued further on.

The scope of SIH in Québec: A brief overview

Although poverty rates are still too high, Québec measures up relatively well as regards the fight against social inequalities within the North American context and appears to be at the forefront of the fight against poverty in Canada.[15] Like the other Canadian provinces and the United States, Québec has seen an increase in income inequality over the last decade, yet has nevertheless been able to keep its level of income inequality among the lowest in North America.[16]

The section which follows demonstrates that despite a steady improvement in health status affecting all socioeconomic groups in Québec, social inequalities in health between these groups are significant and are even tending to increase over time.[17 18 19 20 21] Data on the scope of SIH in Québec speak for themselves, as Table 1 and Figure 2 show. In the most disadvantaged segment of the population, according to one deprivation index,[a] there are 88% more daily smokers, 28% more obese people, 54% more people dissatisfied with their social life and 93% more people who 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, as shown in Table 1. As an individual's position on the social scale rises due to their income and level of education, they enjoy better health. Thus, while people in Québec who belong to the middle class seem generally to enjoy better health than the poorest people, they are, nevertheless, less healthy than those who belong to the most advantaged group.

[a] A deprivation index was created by Québec researchers in the late 1990s to identify SIH and track changes in SIH over time across Québec.[15] 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.

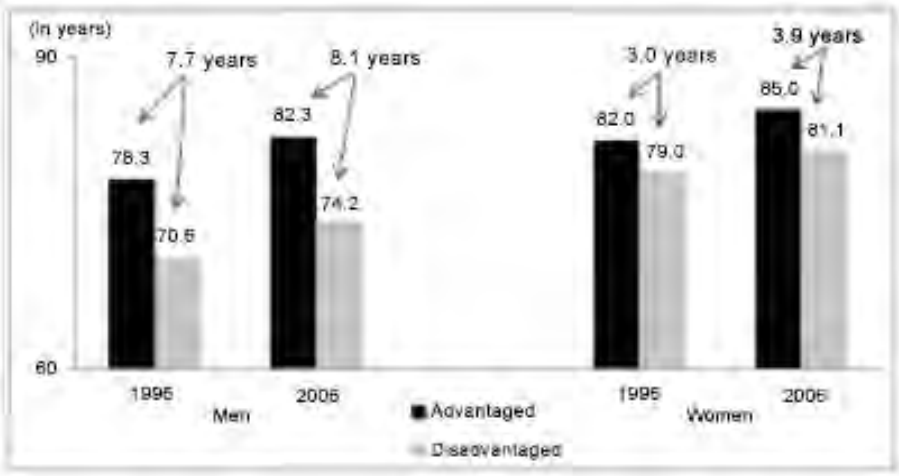
Table 1 Data for 4 indicators drawn from health surveys[b]

	Most disadvantaged group (G1)	Most advantaged group (G5)	Excess observed in the most disadvantaged group*
Daily smokers	27.5%	14.6%	88%
Obese persons	17.6%	13.7%	28%
Persons dissatisfied with their social life	8.3%	5.4%	54%
Persons who do not consider their health to be good	14.5%	7.5%	93%

* (* G1 - G5) / G5 X 100.

There are also marked differences between socioeconomic groups in terms of life expectancy (see Figure 2) and premature mortality. In 1996, life expectancy in the most disadvantaged group lagged behind that of the most advantaged group by 7.7 years for men and 3.0 years for women. Between 1996 and 2006, the most disadvantaged group saw its life expectancy increase by 3.6 years for men and 2.1 years for women. Despite this, the gap between the most disadvantaged and the most advantaged group grew, reaching 8.1 years for men and 3.9 years for women in 2006.

Figure 2 Life expectancy at birth according to gender, for the most advantaged group and the most disadvantaged group, Québec, 1996 and 2006[c]



[b] Proportion of daily smokers aged 18 years and older (2007-2008); Proportion of obese persons aged 18 years and older (2008); Proportion of persons aged 15 years and older dissatisfied with their social life (2008); Proportion of persons aged 15 and older who do not consider their health to be good (2008).

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

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.[22] [23]

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.[24] 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.[25]

How do SIH in Québec compare with those in the rest of Canada?

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 Canadian regions.[26] 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 published by the Canadian Institute for Health Information[d] 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.[27] This applies, in particular, to the Montreal region where the inequalities observed for each of the 21 indicators analyzed were consistently smaller than average.

Aboriginal populations in Québec 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.[28] [29] In Québec, 11 recognized Aboriginal nations represent a little over 93,541 people, or more than 1% of the population,[30] and differ from each other in cultural, linguistic and geographical terms, as well as on the level of legal and political status.

This heterogeneity makes it difficult to sketch a general portrait of the health of these populations. Nevertheless, certain trends emerge: the most pronounced differences are generally observed for intentional and non-intentional injuries, chronic diseases (obesity, diabetes and cardiovascular disease) and for certain communicable diseases (sexually transmitted infections and tuberculosis). Compared with the Canadian population, Québec First Nations people 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.[31] 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(21).

In Canada, 65 of the 100 least healthy communities are indigenous communities assessed according to the First Nations Community Well-Being Index (CWB)[32] which includes determinants of health such as level of education, participation in the labour force, income and housing.

[d] This study on the health gap in urban areas in Canada was carried out by applying the deprivation index to hospitalization data for the years 2003-2004 to 2005-2006 and to data from the Canadian Community Health Surveys, 2003-2005.

A new report by the Canadian Human Rights Commission (2013) shows that:

> "compared to non-Aboriginal people, Aboriginal people living in Canada have lower median after-tax income; are more likely to experience unemployment; are more likely to collect employment insurance and social assistance; are more likely to live in housing in need of major repairs; are more likely to experience physical, emotional or sexual abuse; are more likely to be victims of violent crimes; and are more likely to be incarcerated and less likely to be granted parole."[33]

Most of the conditions that promote good health are severely lacking for a large part of the Aboriginal population in Québec. For many authors, the legacy of colonization and the legal and structural context faced by indigenous peoples are crucial determinants of health.[34] Among the other determinants that have a major influence on Aboriginal health, the most noteworthy are 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 physical and the built environment (e.g., the quality of housing, access to water and sanitation) and lifestyle.[35] The initiatives launched must take into account this particular context:

> "Unhealthy lifestyle habits and difficult living conditions are very often related to discrimination, loss of identity, low self-esteem, and shared suffering associated with marginalization. In prevention and health promotion interventions, it is therefore of primary importance to foster individual and collective empowerment, strengthen cultural factors, cultivate social cohesion, reinforce parenting and social skills, and build self-esteem as well as focusing on healthy lifestyle habits."(31:3)

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(22). 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(22).

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. Intervention with Aboriginal populations should take into account the different decision-making authorities at the national, provincial and local levels as well as the legislative context that specifically frames the governance of issues affecting these populations. This complexity often limits the impact on Aboriginal peoples of established universal measures implemented for the entire population of Québec, thus reinforcing the unequal character of these measures.

1.3 Reduction of SIH and intersectoral action

> "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." WHO, 2008(10)

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[36] and thus rely on intersectoral action. The reduction of SIH also relies on the participation of the different levels of government.

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. This strategy, advanced by the WHO and, in particular, by Finland during its presidency of the European Union in 2006, consists of ensuring that health is taken into account in the policies of all sectors and that all levels of government are involved: supranational, national, regional and local.[37] The reduction of social inequalities in health is one of the issues addressed by this strategy.

The success of such a strategy rests primarily on an explicit commitment at the highest political level as well as on the leadership exercised by the health sector,[38] which usually spearheads this type of strategy. Different **governance** structures can stimulate or initiate intersectoral actions promoting the implementation of HiAP. A recent WHO document, *Intersectoral governance for health in all policies*, identifies the broad structures that enable actors to work together (such as committees and departmental secretariats, parliamentary committees, interdepartmental committees, joint budgeting, etc.) as well as the actions arising from their mutual commitment and their deliberations (i.e., agreements regarding the adoption of specific policies, how to frame them, what policy instruments to use to implement them, etc.).[39]

Health Impact Assessment (HIA) is, for its part, 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 predict the potential effects of a policy, program or project on the health of the population.[40] 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 fairness are central dimensions of HIA and this mechanism can help ensure that SIH, as well as the factors that shape them, are taken into account in policies and projects being implemented.[41] Moreover, various guides and tools have been developed to allow the HIA process to specifically target the reduction of health inequalities. The approaches described are referred to as Health Equity Impact Assessment or Equity-Focused Health Impact Assessment. In reference to this subject, a document by the NCCHPP explains: “It has been observed that HIA practitioners do not always take an equity focus into account in a satisfactory manner. This was discussed by an international round table of HIA practitioners and it was generally agreed that it would be better to strengthen the equity dimension within a generic HIA framework rather than to develop parallel practice focused solely on how policies affect inequities.”[42] Attention to SIH in HIA often requires a participatory approach and the involvement of the population affected, which promotes the adoption of decisions that are best suited to the needs of populations and provide the greatest benefits to the community.[43]

Note, however, that despite the emphasis on government intervention in this document, a synergistic approach involving the whole of society, including the community, the private sector, and citizens is paramount to addressing an issue with ramifications as complex as the reduction of SIH.

1.4 Reduction of SIH and socio-political context

To better understand this social issue, it is necessary to supplement the populational analyses developed by the public health sector with consideration of the broader socio-political context. Political, economic, social and cultural contexts profoundly affect the life, health and well-being of individuals. 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. For example, it is important not

to underestimate the considerable impacts of globalization and of population changes caused by global migrations on societies and on national economies. It suffices to consider the consequences for the labour market and labour force, the transformations of corporate cultures, and the redefinition of social values prompted by these economic pressures and cultural shake-ups. Similarly, the mass arrival of women in Western labour markets since the 1960s has brought many changes. Another noteworthy phenomenon is social mobility, which has greatly increased, allowing a certain segment of the disadvantaged population to access better living conditions, but causing those who were unable to take advantage of this mobility to become even more vulnerable and impervious to intervention.[44]

It is also important to take into account the contexts of the political systems of the various countries studied. For example, the institutional framework of a government can have an impact on a government's ability to act. This is the case for the federal context in Canada, where the sharing of jurisdictions between the federal and provincial levels influences government intervention. 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. While it may be the responsibility of government to respond to the needs of its citizens and compensate for the shortcomings of the market through some redistribution of wealth, there are, nevertheless, multiple options for developing this role and intervening. This raises questions concerning the respective responsibilities of the government, individuals, families (particularly women) and the community for ensuring the well-being and inclusion of citizens.[45] Although perspectives on how these responsibilities should be shared directly affects the type of social policies implemented by a government, the results of policies remain mixed with regard to the reduction of SIH, and this is so even under social democratic welfare regimes, known for investing in stronger, universal government intervention. In fact, an improvement in the health status of populations does not necessarily coincide with a decrease in inequalities, but can just as likely be accompanied by an increase in the latter[46](44). Thus, universal measures may indirectly favour the more affluent population groups because these groups are often more able to take advantage of existing measures(44). As mentioned earlier in the discussion of the theory of fundamental causes developed by Link and Phelan, access to resources is at the root of social inequality(13). For example, in Sweden, interventions to combat smoking were notably successful for the whole of the population; however, the most disadvantaged population groups benefited less from these measures, leading to a widening of the gap in the smoking rate between social groups(71). Special attention and specific arrangements are often required to truly succeed in reaching the most disadvantaged individuals and groups with universal government measures.

This touches on the phenomenon of exclusion. Exclusion is a multidimensional and dynamic process that determines whether individuals are integrated into society.[47] 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 Reduction of SIH: comprehensive government approaches observed elsewhere in the world

Experience actively combating SIH has been gained by a few countries which, each in their particular political context, has favoured a broad approach encompassing several sectors of intervention. The United Kingdom, Finland, Sweden, Norway, Australia and New Zealand are countries whose expertise in this area is recognized and whose experiences are well documented. This section examines interventions aimed at reducing SIH in the above countries which have adopted a systematic approach to reducing SIH that could prove highly instructive for Québec, despite its status as a provincial government acting within a federal context. Some of these policies differ with respect to the government authorities directing them; some are applied by the whole of government, others are instead developed and supported by the health sector according to the dictates of a national public health policy that addresses the social determinants of health. The extent to which the population is covered is another differentiating factor. While some countries provide universal coverage, others prefer an approach that targets particularly disadvantaged groups or communities, or opt for a proportionately targeted universal approach, that is, universal interventions, whose funding and implementation is modulated according to need across the social health gradient.[48] In addition, many countries have focused their SIH reduction efforts on changing the behaviours and lifestyles of individuals, while others prefer to act on structural factors, such as education, social protection and the labour market. Regardless of these variations in policy, the governmental approaches presented in this section were all primarily designed to achieve a specific goal: the reduction of SIH.

2.1 United Kingdom[e]

The United Kingdom was the first country to adopt a comprehensive policy specifically aimed at reducing SIH. So far, few countries have implemented as systematic an approach based on a series of independent reports, on a logical intervention program, and on evaluations of the progress achieved. 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.[49]

[e] We are considering here the United Kingdom as a whole even though, since the end of the 1990s, the power to legislate on health has been devolved to the English, Scottish, Welsh and Northern Irish governments. This is because intervention aimed at reducing SIH involves all sectors and in particular tax policies, which are still largely determined by the United Kingdom for all the nations. See Chapter 4 of the following work: Raphael, Dennis. 2012. *Tackling Health Inequalities: Lessons from International Experiences*, Canadian Scholars' Press Inc.,Toronto.

Historical context of the struggle 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 early on with the ***Black Report*** commissioned in 1977 by the Labour Government. This report, published in 1980, examined the trend toward an increase in social inequalities in health between workers, dependant on their socio-professional category. However, with the election of a conservative government, the issue disappeared from the agenda until 1998 and the return of the Labour government, when inequalities were again examined in the important Acheson Report,[50] 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 new policies for reducing poverty and income inequality, such as social protection, employment, housing, transportation and agriculture measures, and also by revising the role of the health care system. Therefore, the following year, the government launched its strategy in the white paper *Saving Lives: Our Healthier Nation*[51] and produced an initial action plan, *Reducing Health Inequalities: An Action Report*,[52] focused on the reduction of social and geographical inequalities of mortality, and aimed at improving the health of the most disadvantaged as well as at reducing health gaps between groups. 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. Local authorities are now encouraged to include these objectives in their agreements with the central government and can even receive financial rewards based on their performance.[53] In 2003, the government developed a transversal action plan, *Tackling Health Inequalities: Programme for Action*,[54] which solicits the participation of twelve governmental departments and agencies in the fight against inequalities and proposes four major areas of intervention: 1) supporting families, mothers and children; 2) engaging communities and individuals; 3) preventing illness and providing effective treatment and care; and 4) addressing the underlying determinants of health.

Despite the scope of this SIH reduction strategy, a *National Audit Report*[55] 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. The report concluded that the measures initiated were undertaken too late to achieve the desired objectives within the period specified.

In response to a request from the Secretary of State for Health, Sir Michael Marmot published the report *Fair Society Healthy Lives*[56] whose aim was to identify the best SIH reduction strategies comprising policies that address the social determinants of health and to discuss their adaptation for the 2010-2020 period. Intent on breaking with past policies targeting disadvantaged groups and sectors, this report recommends adopting universal, but proportionately targeted, actions to reduce the gaps between all groups. It also recommends the coordinated action of central and local governments, the private sector and communities.

In 2011, the current coalition government published its national public health strategy, *Healthy Lives, Healthy People*[57] which emphasizes continued action to combat SIH, as recommended by Marmot. 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, slated to become effective in April 2013.[58]

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. Without being directly involved in policy development, this unit liaises with all government agencies and ensures that SIH are integral to the concerns and efforts of other departments.[59] Since 2004, programs and policies have been subject to a HIA procedure, which departments must initiate early in the 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.[60] The National Institute for Health and Clinical Excellence (NICE) for its part evaluates health interventions and disseminates available relevant evidence.

2.2 Finland

Finland was one of the first countries to develop a national policy on population health with the explicit aim of reducing inequalities in health through its strategy *Health for All by the Year 2000 – The Finnish National Strategy*[61] adopted in 1986. Finland is also recognized for its leadership in the development of the "health in all policies" approach.

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*[62] 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.[63] This plan recognizes the potential of a health in all policies approach for reducing SIH and stresses that organizers should ensure collaboration between administrative sectors and between the various agencies and actors. The interventions included in this action plan are focused on three priority areas: firstly, social policy measures aimed at reducing poverty, improving student success and retention rates and promoting health in schools, particularly through vocational training, access to employment, health promotion in the workplace, the fight against homelessness and access to housing; secondly, the promotion of healthy behaviour through universal measures or those targeting vulnerable groups; and finally the improvement of access to social and health care services by ensuring collaboration between these two sectors, strengthening child and family services, improving the flexibility of rehabilitation services and strengthening mental health services and services for the elderly and immigrants.

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. These include the following set of programs: *Policy program for employment, entrepreneurship and worklife 2007-2011*,[64] *Policy program for the wellbeing of children, youth and families 2007-2011*,[65] *Government Resolution on Development Guidelines for Health-Enhancing Physical Activity and Nutrition* (2008)[66] and *Alcohol Program 2004–2007*.[67] It should be noted that some of the objectives of these policies were expressly included, or even strengthened, in the *2008-2011 National Action Plan* mentioned previously.

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*[68] aimed at reducing persistent inequalities in health and welfare. This strategy includes objectives such as lengthening working careers by three years by 2020 through measures that promote employment for all for as long as

possible, reducing absenteeism in the workplace, ensuring the sustainability of social protection programs and improving the quality of the environment.

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.

2.3 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 Swedish social protection system, within which the principle of universality is applied to all policies, can be viewed as an approach to reducing social inequalities. Human dignity, health needs, solidarity and the concept of cost-effective care are the four principles on which health is based in Sweden.[69]

Adopted in 2003, the *Swedish National Public Health Policy*[70] 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." The primary objective of this comprehensive policy is to create the social conditions necessary for health equity. Eleven priority areas covering the main determinants of health guide the government's actions. The first five relate to the structural causes of SIH, namely citizen participation and social inclusion; economic and social security; living conditions during childhood and adolescence; health in the workplace and finally environmental conditions and consumer goods. Two focus areas are related to the health care system, with particular emphasis placed on the importance of health promotion and the prevention of infectious diseases. The last four focuses are sexuality, physical activities, and habits surrounding the consumption of food, drugs and alcohol.[71]

In 2007, following the election of a new government, this policy was renewed, with some adjustments that place greater emphasis on individual responsibility.[f] Taking a broad view of the life course, the renewed policy focuses, for example, on improving the early living conditions of children and youth by promoting initiatives that support parents and strengthen their abilities. The *National Strategy for Parental Support*[72] implemented in 2009-2010 is a broad-ranging strategy whose aim is to provide support for all parents of children aged between 0 and 18 years old. Social exclusion was targeted as a threat to public health, and several other programs or interventions were also implemented beginning in 2007 to counter this.

According to the Swedish perspective, intersectoral collaboration is required to achieve the objectives of this policy. Therefore, the public health research and practice communities work in partnership with decision-making bodies (national, regional and municipal)[g] in an effort to promote health in all policies. The Swedish National Institute of Public Health (SNIPH)[73] is the expert government agency responsible for the monitoring, implementation and evaluation of national policy, for the transfer of knowledge about public health and for providing support for communicable

[f] See the new policy guidelines: http://www.sweden.gov.se/sb/d/15471/a/200182.

[g] In Sweden, there are three independent levels of government: the national government, county councils and communes(21) and municipalities(290).

disease control. Since the greater part of these tasks is devolved to regional and local bodies, this agency works together with the various sectors as well with several levels of governance.

The 2010 SNIPH report on the policy reaffirmed the SIH reduction priorities, stating that at this stage the most important factor associated with improving population health is the creation of healthy living environments.[74] The recommendations made to the government include, in particular, discussion about establishing indicators for social sustainability and developing a model for the monitoring of socioeconomic inequalities in health. There is also mention of the advantages of legislation touching on municipal responsibility for public health, requiring municipalities to develop a detailed public health plan. Regarding results, Swedish statistics compiled over the last twenty years point to a notable improvement in the general health of the population. The most recent results regarding health determinants indicate significant improvements at several levels between 2004 and 2010. The decrease in the prevalence of smoking is one of the greatest improvements. However, progress has been slower and more limited within the most disadvantaged populations, which could contribute to exacerbating inequalities in health. This calls for vigilance, because despite a certain degree of continued support for the Swedish social democratic model, this trend could continue, or even worsen given the re-election of a centre-right government in 2010.

2.4 Norway

Like its Swedish neighbour, Norway has in recent years seen the overall health of its population improve.[75] This country ranks first according to the Human Development Index.[76] 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. Here, defence of the social democratic project and its values are central to the aim of reducing SIH. Norway is also distinguished by its assertive approach to health promotion and its intersectoral action. 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.

Aligning its efforts with the social democrat political tradition in place, Norway has undertaken to tackle SIH through a process of revitalization of its universal and structural measures. The *Norwegian Public Health Act*[77] 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 to Reduce Social Inequalities in Health*[78] is a comprehensive strategy, presented and approved in 2007 by the Norwegian government, that tackles the problem by seeking to promote equity as "good public health policy." This aim of this strategy is to pursue 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*,[79] published in 2005. It revolves around four priorities: 1) reduce social inequalities that contribute to SIH; (2) reduce SIH in health behaviour and the use of health services; (3) encourage targeted initiatives to promote social inclusion; and 4) develop knowledge and cross-sectoral tools.

The Norwegian strategy for combating SIH emphasizes the need for intersectoral work. It is aligned with the national health policy, the *National Health Plan for Norway 2007-2010*,[80] and also with the interventions included in the employment, social protection and inclusion program, *Work, Welfare and Inclusion 2006-2007*,[81] with the action plan for combating poverty, the *Action Plan Against Poverty 2008*[82] and with the policy on intervention in education, outlined in *Early intervention for Lifelong Learning 2006-2007*.[83] Thus, although overall responsibility for the strategy falls to the department of health and social services, it requires the adherence of other departments to be

successful. The Norwegian Institute of Public Health[84] under the direct authority of the department acts together with the Norwegian Directorate of Health, the Norwegian Board of Health Supervision and the Norwegian Medecine Agency. The municipalities and counties also play a key role in implementation by providing services (health promotion, primary health care) and assuming responsibility for land use planning and development. As early as 2003, the report *Prescription for a healthier Norway*[85] stated that the responsibilities of each of the decision-making bodies should be established in a transparent manner and expressed in the national public health policy. This observation was reiterated in the 2010 report *Health Promotion –Achieving good health for all*,[86] which adds that the crucial task for the department of health and social services is to work to ensure that its sectoral partners are not perceived merely as agents implementing public health policies, but rather as actors advancing their own objectives related to health and equity.

2.5 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.[87] Over 700 projects stem from this initiative, which provided the foundation for subsequent actions targeting inequalities.

The Australian federal government supported the *Equity-Focused HIA Framework*,[88] published in 2004 and intended to encourage the execution of health impact assessments focused on equity. The government also funded research on inequalities, such as that carried out under the *Australian Health Inequities Program*.[89] 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*.[90] This integrated national strategy commits all levels of government to improving the living conditions of Aboriginal people, and in particular to improving children's health, and to reducing the gap in life expectancy between Aboriginal people and the rest of the population.

The national reform of the health system undertaken in 2007 was centered on the concept of prevention and led the federal government to seek the advice of the *National Preventative Health Taskforce* regarding interventions and strategies whose implementation could reduce the burden of disease associated with obesity and with the consumption of tobacco and alcohol. The expert group's report submitted in September 2009 and entitled *Australia: The Healthiest Country by 2020*[91] identifies targets and guidelines to follow to effectively implement a series of proposed actions and especially to encourage individuals to change their behaviour and to adopt healthy lifestyles. The reduction of socioeconomic and geographical health inequalities is central to this report, particularly with respect to the need to tackle differences affecting Aboriginal people. The Australian government responded to the recommendations of the Taskforce in 2010 with a health prevention strategy that it qualified as bold, *Taking Preventative Action – A Response to Australia: The Healthiest Country by 2020*.[92] Through this strategy, the federal government committed itself to supporting and implementing the majority of the suggested actions, such as the *National Strategy for Food Security in Remote Indigenous Communities*, which is aimed at increasing the availability and quality of fresh food. Schools in disadvantaged communities were allocated funding for seven years under the *Smarter Schools National Partnership for Low Socio-economic Status Schools Communities Program*, aimed at supporting the learning needs and wellbeing of children in 1700 schools.

Some Australian states have attempted to address the issue of SIH more comprehensively, 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*.[93] Spearheaded by the Ministry of Health, this policy identifies health equity as

one of the main objectives of government as well as priority areas and action strategies for reducing health inequalities. 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.[94]

As recommended by the Taskforce and also by the *National Health and Hospitals Reform Commission's Report*,[95] the federal government created, in 2010, the Australian National Preventive Health Agency.[96] The mission of this national institution is to be a catalyst for strategic partnerships with all sectors and at all levels of government to promote health and reduce inequalities and to initiate actions to promote health across the country(96). It supports research, development and implementation of various preventive initiatives targeting obesity, and tobacco and alcohol consumption. It also ensures the monitoring and evaluation of strategies, so that lessons learned can be disseminated and the progress achieved can be extended in the future.

2.6 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 assessments (HIA) and the intersectoral approach adopted by this country make it an example worthy of interest.

Beginning in 1998, specifically with the publication of a report from the National Health Committee (NCH) entitled *The Social, Cultural and Economic Determinants of Health in New Zealand*,[97] the problem of inequalities became a health priority. The awareness it raised among decision-makers led to a reform of the health sector resulting in the adoption of the New Zealand Public Health and Disability Act[98] in 2000. This Act guaranteed the public funding of health care and ensured the creation of new participatory mechanisms for persons with disabilities and for the Maori community, both of whom were invited to participate in the decision making process for policies affecting their health, in accordance with the Treaty of Waitangi. The same Act also mandated the creation of a public health advisory committee responsible for providing advice the Minister of Health concerning the social determinants of health. Its role was to become a key player in the fight against SIH. In 2002, the Ministry of Health proposed the *Reducing Inequalities in Health*[99] strategy which targets intervention at four levels: 1) structural factors (tackle the root causes of SIH, that is the social, cultural, economic and historical factors that determine health status); 2) intermediate factors (target material, behavioural and psychosocial factors that mediate the impact of structural factors on health); 3) health services (undertake specific actions within health services); and 4) impact (minimize the impact of disability and illness on socioeconomic position). These interventions are carried out at the national, regional and local levels.

Over the last decade, in accordance with the established guidelines, several equity-promoting policies (*Working for Families*,[100] *Whanau Ora*[101]) have been implemented and many intersectoral initiatives have emerged across the country. During the *Marmot Symposium*[102] organized in 2011 by the University of Otago, this progress toward reducing inequalities was applauded and envisioned as a firm foundation on which future interventions could build. With respect to equity for example, the *Health Equity Assessment Tool* (HEAT),[103] 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,*[104] although they are not mandatory. In addition, the *Intersectoral Community Action for Health* (ICAH) program emphasizes the community's participation in and commitment to the decision-making process focused on reducing inequalities. Implemented in four disadvantaged communities, this program demonstrates the importance of the different government sectors and various local organizations working together to achieve their objectives.[105] On the other hand, the voluntary participation of the population, and in particular the Maori population, represents a challenge in the disadvantaged regions, still hindering more significant advances in terms of social inclusion.

While all these interventions may have contributed to an overall improvement in the life expectancy and the health status of the population, inequalities (especially economic ones) have nevertheless continued to increase in New Zealand.[106] Promising avenues are being explored. For example, a recent survey on the perception of poverty and socioeconomic inequalities demonstrates that this perception plays an important role in the development of appropriate political measures.[107] Thus, by contextualizing and widening the view of poverty held by the majority of New Zealanders, the government will be able to more easily promote certain policies which are likely to be more effective and sustainable in the current context. Finally, the close monitoring of indicators of health and of SIH is another factor that should be underlined. In addition to reports by the Director of Public Health and the Ministry of Health, other reports are produced annually, including that of the Office on the Status of Disabled Persons, the Ministry of Social Development and the Ministry of Employment, which includes indicators of social and economic well-being for ten areas linked to population health.

Key points regarding 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. Political stability has tended to foster the development of these interventions over several years. Many of the countries examined have been able to count on political mobilization around the issue of SIH aligned with the social values and social protection systems already promoted by those governments; for example, Norway, whose strategy builds on the pre-existing universal social support system, or the United Kingdom, which has benefited from the strong political will of the Labour Government.

All of the countries discussed recognize the need to work intersectorally to address SIH. The comprehensive 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 mandated expert organizations to carry out knowledge transfer activities and to monitor and evaluate interventions. Several of these countries find it useful to carry out HIAs. In addition, it appears that regional and local authorities often play a key role in implementing comprehensive approaches since, in many cases, interventions are carried out at these levels of governance. Thus, comprehensive approaches often complement regional and municipal interventions.

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 equity and other 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. Sweden, for example, has succeeded in considerably improving the overall health of its population, but SIH continue to grow, although they are growing less rapidly than elsewhere in the world. In general, several European countries (Finland, Sweden, Norway, the United Kingdom and others) have more interventionist public policies than other countries, but show no evidence of having systematically reduced SIH. Variations in inequalities between countries could be attributable in part to deaths related to tobacco or alcohol consumption, as well as to those that could be prevented by health care system interventions.[108] 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 strike a balance between universal measures that affect the entire population and measures that proportionately target disadvantaged groups without stigmatizing them.

3 Reduction of SIH: 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,[109] 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, 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. This section outlines actions taken in Québec that have the potential to help combat SIH, including strategies for intersectoral action developed in Québec, as well as some initiatives advanced by the public health sector, a sector particularly concerned by this issue, notably through its national public health program which includes guidelines for addressing health inequalities. Since Québec-wide initiatives are likely to be influenced by policies adopted at the federal level, a brief overview is given of the Canadian federal context and of Québec's margin for manoeuvre for intervening with respect to SIH.

Although the Québec government has not so far adopted a comprehensive approach to the reduction of SIH, there have been noteworthy initiatives aimed at ensuring coherent government action or raising awareness among the population and policy makers about issues tied to SIH.

3.1 Intersectoral action

Following a long process of citizen and community mobilization driven 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[110] (Bill 112) and the National Strategy to Combat Poverty and Social Exclusion, under the theme, *The Will to Act, The Strength to Succeed*[111] intended to "progressively transform Québec, over a ten-year period, into one of the industrialized societies with the least poverty." This national strategy involves the mobilization of all sectors of activity and its third objective is "to reduce inequalities that may be detrimental to social cohesion." Two action plans followed in 2004 and 2010 to support the implementation of the strategy.

To ensure coordination of the efforts of the various sectors in matters relating to health, well-being and poverty reduction, the Québec government introduced in its Public Health Act (2001)[112] and in An Act to Combat Poverty and Social Exclusion (2002),[113] two articles with an innovative impact: Section 54 and Section 19.

Section 54 of the Public Health Act[114] 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.

Under this HIA mechanism, governmental departments and agencies are now responsible for carrying out prospective analyses of the potential impacts of their decisions on the health and well-being of the population. The department of health supports this process, in particular, through the

development of tools, such as a practical guide[115] and background papers on the determinants of health.

The Comités ministériels permanents du Conseil exécutif[116] [standing ministerial committees of the executive council], 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. Although the health impact assessment should be carried out at the very beginning of the decision-making process, the MSSS is not always consulted during project development. The committees that examine the political, legislative and regulatory initiatives tabled by the different government departments and agencies may decide that an HIA should be carried out and may request the opinion of the MSSS regarding potential health impacts. 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 new Parti Québécois government.

Section 19 of the Act to Combat Poverty and Social Exclusion[117] is closely modeled on Section 54 and, for its part, provides for the adoption of policies that help improve the economic and social conditions of individuals and families experiencing poverty and social exclusion. In other words, “this impact clause requires that each policy be analyzed - before its implementation -using an evaluation grid to verify if the policy will further impoverish some segments of the population, or impede their efforts to escape from poverty or exclude them from a given activity sector” [translation] (Bill 112).[118] 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.

A report from the Canadian Council on Social Development has stressed the importance of the impact clauses incorporated within these two Acts which:

> "reflect the interest in more coherent public action and seek to promote an integrated vision of the problems of poverty, exclusion and inequalities in health. Insofar as impact clauses demand assessment of the effects of government laws, measures and regulations on the daily lives of disadvantaged citizens, they represent a real advance towards an intersectoral and multi-dimensional approach. These clauses also support the development of transversal policies for the most vulnerable in society and attempt to tie together the social, economic, health, cultural and environmental dimensions of poverty"[119] [translation].

The Government Sustainable Development Strategy 2008-2013,[120] 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 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)[121] [interdepartmental committee on sustainable development], facilitates the implementation of this government strategy.

Finally, knowledge building and scientific monitoring of the effectiveness of government interventions targeting SIH would help guide the government through the process of selecting and reviewing its interventions. Since this area of research and monitoring falls directly into one of the three priority focus areas of the recent Politique nationale de la recherche et de l'innovation 2014-2019[122] [national policy on research and innovation], namely, demographic changes and the adaptation of societal organization, promoting research in this area appears to fall within the scope of the Québec government's mandate.

Although they do not constitute in themselves SIH-reduction policies, these strategies for intersectoral action constitute, by virtue of the policy processes that they establish, levers for government action in this area.

3.2 Initiatives advanced by public health authorities

Some initiatives advanced by the public health sector also function as levers within the Québec context of SIH reduction. These initiatives rely on intervention at various levels, including that of the central government and the regional and local levels. They are developed in parallel to health care and services programs, which help combat SIH by providing the Québec population with free universal coverage for care, and providing medication at a lowered cost. To begin with, it should be noted that 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 updated in 2008, identified the reduction of health inequalities as one of the four main challenges associated with its planned activities. This program, which is not a comprehensive SIH-reduction policy mainly, targets the regional and local levels. 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.[123] However, these intentions attest to the awareness of this issue in Québec. For example, the publication of the first *Annual Report on Social Inequalities in Health* by the Montréal-Centre Director of Public Health[124] in 1998 led to the creation of the Observatoire montréalais des inégalités sociales et de la santé[125] [Montreal observatory on social and health inequalities], establishing partnerships between the department of public health and the academic research community. The same year, a ministerial committee focused on the reduction of health inequalities related to poverty was established and in 2002 the committee published a report on the subject entitled *La réduction des inégalités liées à la pauvreté en matière de santé et de bien-être : Orienter et soutenir l'action!*[126] [reducing inequalities in health and well-being related to poverty: guiding and sustaining action]. In addition, a 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*,[127] the creation of the Réseau québécois de développement social[128]

[Québec social development network], 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 public health directors published reports entirely devoted to the issue of SIH in their respective regions: These include the second report[129] on SIH from the Montreal Director of Public Health in 2011, that of the DSP (director of public health) for the Mauricie and Centre-du-Québec region in 2012,[130] and that of the Capitale-Nationale region in 2013.[131] All these publications attest to the relevance of reducing SIH and the willingness of many public health actors to work to achieve this.

Efforts made by public health actors to advance initiatives that prioritize the reduction of social inequalities in health have brought this concern to the attention of decision-making bodies in the health sector. However, public health actions, particularly measures aimed at changing behaviour within the general population, often have adverse repercussions for SIH, because they reach advantaged groups more easily than disadvantaged population groups, thus accentuating health gaps. Sustained effort must be devoted to proposing interventions that are proportionately targeted across the entire social gradient in health and to working with other sectors to influence major determinants such as income, for example, in order to develop truly effective interventions for reducing SIH. Similarly, synergy between government action and social action (for example, community interventions and citizen initiatives) could more broadly support intervention addressing SIH.

3.3 Canadian context and federal government policies

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*,[132] published in 2008, or the reports of the Subcommittee on Population Health of the Standing Senate Committee on Social Affairs, Science and Technology,[133] acknowledge the importance of tackling this growing problem in the country. Nevertheless, the Canadian federal system and the shared authority over social matters that it implies for Québec are key to understanding and analyzing interventions targeting social inequalities in health.

Health care

The Canadian constitution gives provinces and territories primary responsibility for health care. However, the federal government may intervene in this area by means of its specific powers, and in particular through its spending power.[134] One of the federal government's major initiatives is the Canada Health Act,[135] which regulates health care insurance by dictating the principles with which provincial health systems must comply to obtain federal transfers. Its main objective is to protect the well-being of Canadians and provide them with access to universal and free health services. Thus, the federal government contributes significantly to the orientation and financing of health care delivered by the provinces. Any reform leading toward a decline in federal funding puts real pressure on the ability of provinces to intervene and is likely to undermine access to health services. Thus, the 1995 changes to the budget accompanying the creation of the *Canada Health Transfer* and the *Canada Social Transfer* put serious pressure on the provinces to introduce reforms in the area of social services and to make cuts to the care system.[136] In contrast, the reinjection of 41 billion dollars in federal funds over ten years agreed upon in 2004 in the *Ten-year Plan to Strengthen Health Care* has since given provincial governments a certain amount of flexibility as regards the regulation of their health systems. At the end of this plan, expected in 2014, the federal government announced in December 2011 that total cash transfers would continue to increase at the rate of 6% per year until

2016-17. Beginning in 2017-2018, Canadian cash transfers for health will increase according to the growth rate of gross domestic product, with a guarantee of increased funding of at least 3% per year.[137]

Working in parallel with the general orientation and program funding of provincial care systems, several federal interventions, originating outside the health sector, can help reduce inequalities. These mainly relate to providing a minimum income and adequate housing. On the other hand, concerns remain about the consequences of federal reforms in recent decades particularly in the areas of affordable housing, income supplements for the unemployed, and financial assistance for families(134).[138] Recent history seems to confirm this trend with the adoption in June 2012 of Bill C-38, which introduced controversial changes, in particular, to old age security and employment insurance, and abolished the pay equity requirement in federal contracts. Thus, by affecting certain social determinants of health, for example through changes to the minimum income threshold, this omnibus Bill could ultimately have negative consequences for SIH.

Income security

The main federal transfer payments provide funding for the unemployed, the elderly and families. Unemployed persons may receive *Employment Insurance Benefits*[139] while seniors receive *Old Age Security*[140] which complements the *Guaranteed Income Supplement*[141] and other benefits reserved for low-income elderly persons. Although the latter programs have contributed greatly over the decades to reducing poverty among the elderly, successive reforms applied to the employment insurance program have gradually limited protection for unemployed persons and restricted their access to the program.[142] Given that low income individuals are more likely to hold precarious jobs and to experience episodes of unemployment entailing potential health consequences, these changes to the employment insurance program contribute to increasing health inequalities. Moreover, these changes affect the health and income protection systems of the provinces, which are responsible for the health system and for providing assistance of last resort, in their respective jurisdictions.

Regarding transfers to families, the *Canada Child Tax Benefit*[143] is available to eligible families, supplemented by the *National Child Benefit*[144] (NCB) and, in some cases, by the *Child Disability Benefit*.[145] The NCB is a joint initiative of the federal and provincial governments designed to reduce childhood poverty. Québec has adopted its own comparable programs for combating childhood poverty (these are described below in the section on early childhood and education), since it chooses not to participate in the federal initiative so as to maintain control over income support for Québec children.[146] The *Universal Child Care Benefit*,[147] a taxable child benefit of $100 per eligible child, paid monthly, supplements the transfers provided to families[148] but remains a controversial measure. Indeed, because this benefit is granted to eligible parents whether a child is in daycare or remains at home, it does not equally benefit disadvantaged children at home, who would gain more from regular attendance at a preschool daycare centre, in particular because of the extra cognitive stimulation or the early detection of developmental or behavioural problems. Direct transfers to families would also potentially carry the disadvantage of reducing the availability of quality child care services in addition to encouraging mothers to stay at home rather than to enter the labour market.[149]

Funding for housing

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. In recent years, in order to address the shortage of rental housing, and especially of affordable housing, in most cities and in indigenous communities, the CMHC has offered financial assistance[150] for the construction of housing that is affordable and modest in size and design. Nevertheless, the decision of the federal government in

1996 to withdraw, after 50 years of involvement, from the administration and funding of social housing[151] has led to a considerable slowdown in the construction of social housing in addition to compromising the maintenance and renovation of existing social housing. The effects are such that the United Nations Commission on Human Rights, in a 2009 report on housing in Canada, decried the decrease in funding for social housing and the impact of the federal withdrawal on the price and quality of housing. This report identified several groups within Canada who are vulnerable as regards housing, including the homeless and those at risk of becoming so, low-income women and Aboriginal people living on reserves, where overcrowding is among the problems.[152]

Thus, whether initiating policies and programs arising directly from the health sector or involving any other sector that can positively affect the determinants of health, the Québec government is acting within the context of the Canadian federal context and must adjust to the direction and initiatives taken at the federal level, even sometimes acting in partnership.

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

Implemented in conjunction with 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. In the few countries that have adopted a comprehensive approach to reducing SIH, such governmental policies or actions, initiated and coordinated by the health sector or spearheaded by other sectors, often also help consolidate the efforts undertaken in the context of the comprehensive policy for combating SIH. As with a comprehensive approach, policies focused on one or more specific determinants can take the shape either of universal measures targeting the entire population, or of targeted measures aimed at vulnerable populations. These measures may directly target the individual (e.g., a tax credit) or they may target an entire community (e.g. an urban development plan). They are implemented by the central government at the local or regional level, or by the private sector, foundations and the community sector.

The following section describes government interventions focused on specific health determinants implemented in Québec and elsewhere. These are grouped into five main categories, namely: 1) early childhood and education; 2) employment, income and social solidarity; 3) the environment and land use planning; 4) lifestyle; and 5) health care and health services systems.

With regard to the interventions developed in Québec, there is little data on the implementation and impact of the various measures presented in the following sections. Although an abundance of interventions exist in Québec, it should be recalled that many of these interventions have not been fully implemented and that in several cases, the sustainability of these measures is far from assured. In addition, because these interventions derive from different sectors and are not implemented specifically to reduce SIH, the effects of these interventions on SIH have not been evaluated.

4.1 Early childhood and education

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.[153] Early childhood has become a focus due to recent research in the fields of psychology and neurology that demonstrates just how sensitive to external stimuli brain development is during the first few years of life, and how lasting these effects are.[154] Not only do difficult situations experienced in early childhood have an immediate impact on a child's health and chances for success, but SIH that begin at that age continue to grow over time and persist into adulthood, and this is directly linked to shorter healthy life expectancy.[155 156 157]

Family support, childcare services, and perinatal services

Québec interventions

To provide assistance to families, Québec has adopted the *Québec Parental Insurance Plan*[158] for workers who take maternity leave, paternity leave, parental leave or adoption leave. The Régie des rentes du Québec (RRQ)[159] now administers the *Refundable tax credit for child assistance*[160] which has replaced family allowances and benefits, and the *Supplement for Handicapped Children*.[161]

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* for childcare services, the *Programme de places en service de garde à contribution réduite*.[162] Public daycare centres must follow the *Programme éducatif des services de garde du Québec*[163] [Québec's educational program for childcare centres]. Moreover, all children have access to early childhood educational services as soon as they are 5 years old, and Bill 23,[164] which was adopted in June 2013, grants access to children from disadvantaged backgrounds as soon as they are 4 years old. It should be noted that a founding principle of childcare services in Québec is the reduction of inequalities in the development of children. However, unequal accessibility could counteract this objective since a proportionally greater number of advantaged families benefit from these services(149).

Pregnant women and mothers living in vulnerable situations (poverty, young age, or parents with little education) are eligible to receive *Services intégrés en périnatalité et petite enfance* (SIPPE),[165] [integrated perinatal and early childhood services] from the beginning of a pregnancy until the child reaches age five. Support is offered to families, mainly in the form of home visits, group interventions, support for early educational interventions for children, guidance in accessing community resources and through intersectoral actions aimed at creating environments that support the optimal development of children.

With regard to work-family balance, the Ministère de la Famille (MFA) [department of families] implemented the *Programme de soutien financier aux milieux de travail en matière de conciliation travail-famille*[166] [financial support program for workplaces - balancing work and family] and the norme Conciliation travail-famille[167] [work-family balance standard], to encourage workplaces to establish and implement management practices and measures to reconcile work and family.

Elsewhere in the world, a few countries have committed themselves to ensuring "equity from the start," in the words of the Commission on Social Determinants of Health,[168] and have established policies that promote the development of young children and the success of school-age children, with these policies often targeting vulnerable groups.

Implemented in England (with variants in Scotland, Ireland and Wales), *Sure Start*[169] is an early childhood development program that aims to increase children's chances of succeeding at school and into adulthood, thus reducing poverty and its intergenerational transmission. It works to bring together childcare, early education, family support, health care and health promotion services in a coordinated way. Originally, each local program (*Sure Start Local Programme* or SSLP) could develop services based on the needs of the community and the demands of parents, so the SSLPs were very diverse. However, in response to an evaluation indicating the programme's effects were relatively modest due to the diversity of the programs, the lower than expected participation of the most disadvantaged families, and the short time span before the evaluation[170] and in light of the results of other studies emphasizing the importance of integrated services, these local programs were transformed, as of 2006, into *Sure Start Children's Centres* (SSCCs). The services are more closely

supervised, they are more focused on daycare services and on employment reintegration for parents than on the development of children, and they are accompanied by increased outreach toward the most at-risk families.[171] These centres are not limited to disadvantaged areas and are controlled by local authorities; however, childcare and professional assistance services vary according to the levels of deprivation within sectors. According to the evaluation data from a longitudinal study on participation in *Sure Start*, benefits were recorded, especially for children aged three years old, and this was the case for all groups targeted, including teen parents, single parents and households with unemployment(170). Improvements observed in the areas where the program was implemented include the improvement of children's health (decreases in emergency hospitalization, serious injuries and respiratory infections) and an increase in the number of children recognized as having special needs, which suggests better screening(170). The researchers observed that the most effective *Sure Start* programs were those that favoured the integration of complementary services(170).

While the *Sure Start* initiative is among the most recognized globally and has served as an example for several other programs of the same type elsewhere in the world, other interventions deserve attention. A report by the Innocenti Research Centre, associated with UNICEF, showed that Northern European countries, recognized for their progressive social and family policies, ranked among the highest with respect to the various dimensions of children's well-being.[172] Sweden ranks particularly high. In accordance with its national public health policy, Sweden mainly addresses social determinants in order to ensure good living conditions for all throughout childhood and adolescence, on the basis of evidence showing that these conditions form the basis for lifelong health. The development of parenting skills is also strongly encouraged. Universal support provided during pregnancy is intended to encourage the early development of secure attachment skills and promote the adoption of adequate parenting practices. Parental leaves[h] granted to new parents which can total 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.[173] Finally, Swedish public policies contribute to the development of children through quality childcare services that are almost universally accessible, where university educated specialized educators provide preschool education. 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 work-family balance is the most challenging.

[h] See the *Swedish Parental Leave Act*: http://www.government.se/content/1/c6/10/49/85/f16b785a.pdf.

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 (MELS) [department of education, recreation and sports] adopted the *I care about school! strategy*.[174] This strategy groups together several new or pre-existing interventions, either for universal use or for at-risk students or communities; for example, a reduction in the number of students in primary school classes, help with homework, individual coaching in the event of failure, strengthening of vocational training at the secondary level and strengthening of the *Agir Autrement*[175] [act differently] approach.

The evaluation report on this approach reasserts that, despite the absence so far of proven effects on the academic success of students from disadvantaged backgrounds, this intervention strategy is promising provided substantial changes are made to the way it is operationalized and to the conditions surrounding its implementation.[176]

The MELS also has policy on special education entitled "Adapting Our Schools to the Needs of All Students" accompanied by an action plan: *Conditions for Greater Success*.[177] The *Action Plan to Promote Success for Students with Handicaps, Social Maladjustments or Learning Disabilities*[178] (SHSMLD) proposes varying organizational modes for offering services to students with disabilities or difficulties based on their needs (special classes or integration into regular classes), provides measures to support integration into regular classes (reduction in the number of students, identification of the conditions to be met, occasional release of teachers to participate in consultation activities with other stakeholders or for skills development), support for parents and strengthening of the complementarity of services offered by the education and health and social services networks.

Moreover, the Québec government offers financial aid to students[179] in the form of loans and bursaries, administered by the MELS, in an effort to promote access to education. This program comprises various measures such as the *Work/Study Program*[180] to help balance work and studies.

The *Healthy Schools Program*,[181] under the joint responsibility of the MSSS 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.

An interesting example of a learning support program that can mitigate the impact of social inequality is the Irish action plan *Delivering Equality of Opportunity in Schools (2005-2010).*[182] This action plan focuses on the specific educational needs of children and young people from disadvantaged backgrounds, from kindergarten to high school and is part of a continuum of educational services ranging from pre-school to adult education services. It aims to provide children from disadvantaged communities with a positive learning environment through a set of integrated interventions (*School Support Program*) 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 the provision of services integrated with those of other agencies offering services for the same target clientele. A 2011 evaluation report covering the first three years of the program recorded significant improvements (literacy, numeracy, attendance) despite unfavourable economic conditions.[183]

Another example of an intervention which targets early childhood development, but continues beyond the first years of life, is the program established by the Norwegian government's white paper *Early Intervention for Lifelong Learning*.[184] Implemented in 2006, this strategy introduces various measures for promoting academic success, including early language stimulation (starting in daycare), ongoing follow-up support throughout children's' school years as needed, homework assistance, individual assessment, and adaptation of the educative process as soon as a problem is detected. This strategy also aims to enhance physical activity, supply fruit and vegetables in schools, strengthen counselling services in secondary schools to reduce dropout rates, diversify curricula and internships on offer, and ensure training of teachers and other stakeholders, in addition to offering adult education. The originality of the Norwegian plan is its focus on lifelong learning and the importance it attributes to language development as a pillar of child development.

Key points regarding the early childhood and education determinant

Québec offers a variety of programs to support families during the perinatal period and through early childhood: 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. Such an approach has proven effective in other contexts. However, increased benefits for the development of children would be achievable if the network of early childhood centres, which currently has limited availability, were made accessible to all families who wish to have access and if children from disadvantaged backgrounds, who could benefit the most, were encouraged to use it. 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.[185] The examples from other countries point to promising avenues tied to the flexibility and duration of parental leaves, more generous sums for allowances and benefits, the integration of services and increased focus on at-risk groups, ongoing support provided to groups or individuals at risk of experiencing academic difficulty, and finally, support offered to teachers and school principals.

4.2 Employment, income and social solidarity

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 conditions. 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. First, employment must be well remunerated and secure for any real improvement in health and living conditions to be achieved. However, in recent years in Québec and in many other Western societies, there has been a rise in temporary and non-standard work. The number of workers living in poverty is also growing. Certainly, autonomous or part-time work can be a personal choice, particularly to retain some flexibility in terms of work-family balance. However, according to the Comité consultatif de lutte contre la pauvreté et l'exclusion sociale du Québec (CCLP) [advisory committee on combating poverty and social exclusion], it remains true that given a context of poverty or economic crisis it is often necessary to accept any form of employment, regardless of the associated working conditions or insecurity. Temporary work, which is generally less often unionized, less well-paid and more often carried out by

women, is also becoming increasingly common in Québec, according to this advisory committee. Between 1997 and 2011, temporary work grew by around 47%, while permanent employment growth was only 25%. The number of Québec workers living in poverty or at the limit of the low income threshold is also growing. In 2009, more than 900,000 people, or a little more than a quarter of Québec workers, were working for an hourly rate of $12 or less, which provides little to cope with the cost of living.[186]

Insecurity and low pay are not the only SIH-related employment issues. A Québec survey on occupational health indicates that work-related physical or psychosocial pressures are more common at the lowest levels of the social hierarchy, which reinforces the dynamics that produce health inequalities among workers. The prevalence and severity of occupational diseases appear to vary according to the socioeconomic status of workers: the poorest, the least educated and, in general, the most disadvantaged socio-professional classes experience more illness.[187] Potentially pathogenic factors are, for example, physical working conditions (load, posture, repetitive movements, noise, physical or thermal conditions), low control over tasks, or lack of support from peers or superiors.[188]

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. Indeed, most developed countries have implemented minimum income support policies to assist people unable to meet their own needs, temporarily or for prolonged periods, for various reasons (health, disabilities, family obligations, insufficiently well-paid work, etc.), which also indirectly helps combat SIH.

Social transfers and adequate minimum income

Québec interventions

In Québec, in order to ensure an adequate minimum income, the population has access to the *Social Assistance Program*[189] and the *Social Solidarity Program*[190] both under the responsibility of the Ministère de l'Emploi et de la Solidarité sociale (MESS) [department of employment and social solidarity]. These programs constitute financial assistance of last resort for those who may or may not have severe employment limitations. The *Youth Alternative Program*[191] specifically targets young people under age 25 and comprises an intervention plan for entering the labour market. These three programs allow eligible individuals to receive monthly benefits for living expenses. According to the Centre d'études sur la pauvreté et l'exclusion (CEPE), a research centre focused on poverty and social exclusion, in 2012 the disposable income of persons receiving last-resort assistance varies, depending on the family situation, from between 45.5% and 74.8% of the poverty threshold as measured by the low income cut-off.

The *Québec Pension Plan*[192] is designed to provide persons who work in Québec and their families with basic financial protection in the event of retirement, death or disability. This is a mandatory public plan.

Social protection policies in developed countries take different forms: 1) universal benefits financed by income taxes and other taxes for the whole of the population or certain target groups (seniors, children, people with disabilities); 2) targeted or conditional benefits, also funded by general taxes and income taxes, but accessible only on the basis of income or other conditions (last resort assistance, housing subsidies, certain fee exemptions); and 3) social insurance financed by contributions from employees and employers and available to contributors and their families. These policies include, in addition to various services, social transfers or income replacement, allowing

recipients to cope, in whole or in part, with their material needs. Researchers rank countries on the basis of the combination of these various support measures.[i] For example, in January 2012, monthly cash benefits granted under the minimum resource guarantee (or subsistence assistance) to a single person are €429 in Sweden, €374 in Germany, and €351 in the United Kingdom.[j] However, added to that, in Germany and Sweden, is the equivalent in actual or reasonable expenses for housing and heating (plus, in Sweden, reimbursement of other expenses, such as union dues and contributions to an employment insurance fund). In the United Kingdom, supplementary allowances are also granted 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.

A study has demonstrated that regardless of typology, universal social policies, with more generous benefits are associated with longer life expectancy.[193] Similarly, it has been shown that the generosity of family policies (including all benefits and income assistance) is positively associated with a greater reduction in infant mortality.[194] However, these studies draw no conclusions about the impact of these policies on potential reductions in SIH. It should also be noted that in recent years there is a trend toward free market policies that has led several countries to cut or reduce their income support programs, particularly in Australia, the United Kingdom and more recently in Québec.

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 mobilization strategy *Tous pour l'emploi*[k] [195] [everyone for work], the *Employment Pact*,[196] *Allocations d'aide à l'emploi*[197] [employment assistance benefits], *Subventions salariales*[198] [salary supplements] and *Formation de la main-d'œuvre*[199] [workforce training]. Revenu-Québec is responsible for the *Work premium*,[200] a refundable tax credit for workers with low or medium incomes to encourage them to enter the labour market or to remain employed.

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 entrepreneurship strategy *Stratégie québécoise de l'entrepreneuriat*[201] [Québec entrepreneurship strategy]. The MESS is responsible for overseeing the *Income Support Program for Older Workers*[202] 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)[203] 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.

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[i] An often-cited example is the Esping-Andersen classification scheme comprising 3 types of systems: Liberal, conservative and social-democrat. See Esping-Andersen, G. (1990). *The three worlds of welfare capitalism*. London: Polity. See also Eikemo, T.A. and Bambra, C. (2008). The welfare state: a glossary for public health. *Journal of Epidemiology and Community Health*. 62: 3-6.

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

[k] 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).

Like Québec, a number of other countries have implemented activation policies — that is, a set of programs and measures integrating financial aid and job search assistance for unemployed individuals. These programs rely on collaboration between different levels of government and social support agencies and target a clientele that includes very disadvantaged groups. For example, in 2006 Norway released the white book *Work, Welfare and Inclusion*,[204] New Zealand published *Better work – Working better*[l] [205] and in Ireland the *Pathways to work*[206] program was announced in 2012. In general, in addition to financial support, these approaches offer participants follow-up contact, training and work internships. Sanctions may be imposed in the form of reduced funding or eligibility, if participants fail to attend scheduled meetings or refuse to accept available positions. These programs have the potential to address material determinants (e.g., food and housing) and psychosocial factors (e.g., sense of belonging and usefulness), and they can be effective in terms of reintegrating participants in the labour market, as has been demonstrated in Norway, but their effectiveness varies according to the groups targeted and the economic context.[207]

Data on the impact of these programs on health (particularly long-term health) and on SIH specifically are more rare. The information below is drawn from recent studies and reports[208](209). While some of these programs have succeeded in reducing psychological distress, depression and the risk of suicide, others have not been shown to positively affect health. Where there has been improvement, its duration is undocumented and concerns have been expressed related to the poor quality of jobs (insecurity, low pay, non-standard schedule) that participants must sometimes accept, and which is not conducive to a sustainable (or even temporary) improvement in their health. White[209] even argues that the uncertainty and anxiety generated by insecure or poor quality employment may be just as harmful to health as unemployment. She also raises concerns about the punitive logic underlying some activation programs which could aggravate the chronic stress already being experienced by these populations. Moreover, unemployed persons who fail to integrate the labour market, who represent the vast majority of unemployed persons participating in this type of program,[m] are likely to experience feelings of hopelessness, frustration and reduced motivation following the disappointments and repeated rejections they will have experienced while participating in such activation programs.

Some factors could allow activation programs to produce a positive influence on the health of participants. These include the quality of the follow-up of participants, an enabling rather than a binding approach and favourable implementation conditions. In this regard, still according to White, Quebec would be a relatively good example to follow, especially as regards partnerships between the public and community sectors, the motivating (rather than punitive) nature of the helping relationship that the activation program sets up and the coherent relationship between benefits and services (e.g., work of the Emploi-Québec agency and its partners, Québec family policy, etc.).

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[l] In the case of Norway and New Zealand, the documents cited include other aspects related to labour, for example, working conditions and health and safety in the workplace.

[m] In her study of the health impact of activation policies, White (196) indicates that, depending on the type of program and the national activation system, 50% to 80% of the unemployed persons participating in activation programs could not integrate the labour market, including precarious employment. In Québec, approximately 55% of unemployed persons participating in the employability program are unable to integrate the labour market sustainably (i.e., for over 18 months), at least, not following participation in a single activation measure.

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*,[210] the aim of which is to coordinate actions intended to help disadvantaged individuals and to combat poverty. Working in the same vein, the MSSS is responsible for the new *Politique nationale de lutte à l'itinérance*[211] [policy on combating homelessness] and the *Plan d'action interministériel en itinérance*.[212] [interdepartmental homelessness action plan]. The government also has a *Policy on Community action*[213] that supports organizations defending collective rights and recognizes and supports voluntary work carried out by community organizations. Persons with low incomes have access to legal services through the *Legal Aid Program*[214] administered by the Ministère de la Justice [justice department].

Other measures target specific population groups such as the *Youth Action Strategy 2009-2014*[215] advanced by the Secrétariat à la jeunesse, which seeks to coordinate all government action targeting youth, and the MFA's *Action Strategy for the Elderly*,[216] aimed at promoting the autonomy and quality of life of seniors.

To fight discrimination, the National Assembly adopted the Pay Equity Act[217] to correct wage differences attributable to gender-based discrimination. Similarly, the *Government Action Plan on Gender Equality* (summary version of the *Politique gouvernementale pour l'égalité entre les femmes et les hommes*),[218] seeks to promote economic equality between women and men and a better balance between family and work responsibilities. The MICC's *Government policy to promote participation of all in Québec's development* (summary version of the *Plan d'action gouvernemental pour favoriser la participation de tous à l'essor du Québec 2008-2013*),[219] aims to correct situations where discrimination and inequality affect Québec's cultural communities, and in particular, visible minorities. Finally, the Act to Secure Handicapped Persons in the Exercise of their Rights With a View to Achieving Social, School and Workplace Integration[220] and the policy statement derived from it *À part entière : pour un véritable exercice du droit à l'égalité*[221] [in their own right: for the true exercise of equality], are piloted by the Office des personnes handicapées du Québec (OPHQ) [Québec disabled persons board].

Programs and plans aimed at combating social exclusion often combine several approaches and target diverse clienteles. In Australia, the 2009 social inclusion policy, *A Stronger, Fairer Australia*,[222] is centered on priorities, policies and activities aimed at jobless families, vulnerable children, homeless persons, Aboriginal people and persons with disabilities. This policy proposes integrated approaches for vulnerable neighbourhoods and communities. Another example of a plan to combat social exclusion is Ireland's *National Plan for Social Inclusion 2007-2016*,[223] whose overall objective is to reduce the number of people living in chronic poverty from 4 to 2% by 2012 and to eliminate this type of poverty by 2016. This plan, structured around a lifecycle framework, contains objectives targeting children, people of working age, the elderly, people with disabilities, and communities. The proposed measures cover the areas of income support, education, employment assistance, housing, health services, and integration of immigrants. With regard to the governance, implementation and monitoring of this plan, the intent is to strengthen existing coordination mechanisms and to establish new mechanisms, both horizontal and vertical. A follow-up plan consistent with other governmental agreements and plans and an annual report are provided for under the plan, which is under the responsibility of the Office for Social Inclusion.

Working conditions, health and safety

Québec interventions

The Act Respecting Labour Standards[224] applies to most Québec employees, but excludes self-employed workers and certain categories of employees. It regulates various aspects of employment, such as the minimum wage, the duration of the working week, breaks, leave for family reasons or illness, holidays, hiring and dismissal, contracts and sexual harassment.

Collective agreements between a group of employees and an employer are governed primarily by the Labour Code,[225] which covers the right of association (also guaranteed by the Québec Charter of Human Rights and Freedoms and the Canadian Charter), union certification, collective bargaining, etc.

In Québec, the Occupational Health and Safety Plan is based on two main laws: the Act Respecting Industrial Accidents and Occupational Diseases,[226] and the Act Respecting Occupational Health and Safety.[227] The Act respecting industrial accidents provides compensation for victims of work accidents or occupational diseases and covers all workers (with a few exceptions) who are the victim of a work accident or develop an occupational disease in Québec and whose employer has an establishment in Québec. The Act respecting occupational health and safety aims rather to prevent work-related accidents and diseases and although, in principle, it covers all workers, the Commission de la santé et sécurité du travail [occupational health and safety commission] determines by regulation which sectors must implement a prevention program. In 2012, 25% of Québec workers (35% of male workers and 15% of female workers) were working in a company where a prevention program had been implemented. Working conditions affect both health and SIH.[n] Work-related inequalities are influenced by policies enacted on many levels: at the macro level, for example, international trade treaties, work relations, unionization, the labour market and the minimum wage; at the level of employment conditions, such as schedules, leaves of absence and contracts; at the level of the workplace conditions, such as exposure to various risks and physical and psychosocial stress; and finally at the level of compensation programs for victims of work accidents or professional diseases.[228]

Policies regarding work hours, leaves of absence and daily and weekly rest periods vary according to the length of the workweek (full-time or part-time), the flexibility of the schedule (which can be established at the initiative of the employer or the employee) and the duration of holidays. For example, the Swedish Working Hours Act[229] prescribes a 40-hour work week, a maximum of 200 additional work hours per year, and in general prohibits night work, with some exceptions. In addition, this Act allows Swedish workers flexibility in the organisation of their working time, enabling them to adapt their schedules to the various stages of their lives.[230] In Norway, the Working Environment Act[231] 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, leaves of absence, hirings and dismissals), physical and mental risks and stress, workplace adaptation for vulnerable persons, cooperation between employers and employees, as well as inclusion.

[n] Links between SIH and working conditions have been established by several authors cited by Vézina et al.(235).

France has implemented occupational health plans, the second of which covers the period 2010-2014.[232] This plan notes that the number of occupational accidents has stagnated, that occupational diseases are increasing and that the economic downturn signifies a battle to maintain employment, which requires a more effective primary prevention policy to ensure everyone has the benefit of quality working conditions. It refers to the prevention of professional exclusion, to the development of psychosocial risks, to the threat of emerging chemical risks and to the importance of taking into account the impact of new ways of organizing production processes, especially for SMEs and for vulnerable workers. The plan has several focal points: improving occupational health knowledge, pursuing an active policy of occupational risk prevention, encouraging implementation of prevention measures in companies and, finally, piloting the plan, which includes monitoring its implementation, fostering national and territorial partnerships, strengthening workplace inspections, sharing information and communicating.

Considerations attached to health, income and employment of Québec women

There are significant disparities between men and women in Québec. First of all, women have a higher life expectancy than men at birth: 83.7 years compared with 79.7 years in 2011.[233] This gap however has narrowed during recent years, due to a less rapid increase in life expectancy for women than for men. The gap is much smaller for life expectancy in good health, which is 68.3 years for women and 66.5 for men.[234]

Women suffer more serious problems related to functional health, disability or limitations in their ability to participate in activities, which may be related to their longer life expectancy, since disability increases with age(234). Women are more likely (23.2%) than men (16.6%) to report a high level of psychological distress(234).

Women are half as likely to suffer occupational injuries (accidents and diseases) than men, but they are more likely to suffer from musculoskeletal disorders and mental health problems associated with their work.[235] Their injuries require a longer than average stay in hospital. 85% of women workers versus 65% of male workers are in sectors considered non-priority for the application of OHSA workplace prevention programs.[236] However all workers have access to the Safe working conditions for a safe maternity experience program for pregnant or breastfeeding workers.

In 2010, the average disposable income was $25,100 for women and $33,400 for men; 46.7% of women have a disposable income of less than $20,000, compared to 33.8% of men.[237] With regard to employment income, women have lower incomes than men, even when they work full time[238] or have completed university studies (bachelor's or master's degree).[239] They are less likely than men to hold union-protected positions(235). In 2011, 59.8% of minimum wage workers were women, although women represented only 47.3% of the working population(239). 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 taxes(238).

Firstly, these data illustrate the importance of addressing SIH from various angles, such as that of gender. But beyond pointing to these significant gender disparities, we must also stress that the income and employment insecurity of women has direct consequences on families and children that can lead to poverty and exclusion, which carry long term consequences for the health of the latter.

Key points regarding the employment, income and social solidarity determinant

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 merit being maintained and, if necessary, strengthened, while taking care to develop and ensure the social participation of all

citizens, which would contribute to improving their quality of life and to greater social cohesion. Furthermore, the impact of employment and working conditions on SIH is significant, and examples drawn from other countries can 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.

4.3 Environment and land use planning

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. Land use practices directly impact these three determinants, as well as other dependent determinants, including air quality, safety, exposure to high traffic volumes and speeds, 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 prompts more affluent residents to leave these neighbourhoods, further exacerbating SIH. Conversely, planning measures that promote health (e.g.: green spaces, safe bike paths) that are implemented in disadvantaged neighbourhoods can mitigate SIH. 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

As per the Sustainable Development Act[240] (R.S.Q., c. D-8.1.1), the Ministère du Développement durable, de l'Environnement, de la Faune et des Parcs (MDDEP) [department of sustainable development, the environment, wildlife and parks] has developed the *Stratégie gouvernementale de développement durable 2008-2013*[241] [government sustainable development strategy] which aims to influence and encourage citizens and businesses to use practices aligned with sustainable development objectives. As stated in its directives, this strategy specifically aims to prevent and reduce social and economic inequality.

Sustainable development is globally recognized as a promising avenue, but the practical means of achieving this are multiple. This conceptualization of development that encompasses economic, social and environmental goals can be aligned with public health objectives. Active transportation, food and environmental health are central to many sustainable development plans, even though health and equity are not always explicit goals. Nevertheless, these objectives are essential to the success of sustainable development projects and facilitate concerted action supported by a set of policies. The Sustainable Development Commission (2009-2011) set up by the British government even sees this approach as the best way to combat SIH because it is based on the idea of "ensuring a strong, healthy and just society."[242]

National sustainable development strategies focused on the social dimension are particularly effective mobilizers because they can be aligned with action addressing the social determinants of health. The perspective developed in *Agenda 21*[243] also serves a tool allowing focus to be placed on mobilization, collective action and intergenerational involvement, thus contributing to social inclusion and community solidarity. France based the development of its 2003 national strategy for sustainable

development on the above principles. The lessons drawn from the Profession Banlieue[o] working group which developed this strategy demonstrate the necessity of paying particular attention to the needs of the poorest. According to their analysis, social issues included in development plans often point only to comfort measures (such as the availability of nearby green spaces). Sustainable development should not be aimed only at "greening" various public policies with measures targeting the protection of the environment. It can consist of a much broader territorial project, comprising a social dimension and tackling inequalities through sustained focus on intersectoral implementation. Clearly this requires more time and energy,[244] but it remains a priority when combating inequalities.

Strategic planning and revitalization

Québec interventions

The Act Respecting Land Use Planning and Development[245] (R.S.Q., c. A-19.1) represents the legal framework governing plans for the territorial development of the province of Québec. Responsibility for these plans is delegated to municipalities.

The *Stratégie pour assurer l'occupation et la vitalité des territoires 2011-2016*[246] [strategy to ensure the occupancy and vitality of territories] developed by the government and piloted by the Ministère des Affaires municipales, des Régions et de l'Occupation du Territoire (MAMROT) [department of municipal affairs, regions and land occupancy] is based on the establishment of a new dynamic focused on three areas of intervention: community action, government action and, where necessary, joint action. The Act to Ensure the Occupancy and Vitality of Territories[247] helps ensure the strategy's sustainability. This strategy supports cities in implementing an integrated urban revitalization strategy (IUR),[248] a process aimed at revitalizing neighbourhoods with high concentrations of poverty and insufficient infrastructure. An IUR has three essential elements: mobilization of citizens and partners who jointly produce a diagnosis of targeted disadvantaged sectors and identify priority actions for structuring their environment; implementation of poverty fighting measures in these areas; improvement of the built environment, including housing and rehabilitation of existing infrastructures or development of new infrastructure.

Furthermore, the Fonds québécois d'initiatives sociales established under Act 112, the *Act to Combat Poverty and Social Exclusion*, provides funding, at the local, regional and national levels, to support active mobilization and coordination of stakeholders and projects, for interventions and research aimed at combating poverty and social exclusion in territories with high concentrations of poverty.

In England, the *National Strategy for Neighbourhood Renewal*,[249] initiated in 1999 in the context of the *New Deal for Community* (NDC) program, to counter inequality, advocates an integrated approach to revitalization, targeting neighbourhoods that are among the most disadvantaged.[p] This strategy, focusing in particular on access to public services and community involvement in the planning and implementation of a local improvement plan, is based on local partnerships set up by local authorities and supervised by committees (50% of whose members are from the community). The intervention framework encompasses the following areas: labour and business, health, crime, education, housing, the physical environment and sustainability. This program focuses on the collaborative planning process and its social benefits, including improved living conditions in communities and citizen participation. The evaluation of the program, carried out by the Centre for Regional Economic and

[o] This working group consisted of eight communities engaged in municipal politics and guided by an Agenda 21 or a confirmed desire to engage with this policy. The working group brought together technical teams and, for some communities, elected officials in charge of sustainable development.

[p] At the beginning of the project, 39 districts were targeted on the basis of deprivation rate statistics.

Social Research at Sheffield Hallam University[q] [250] highlights the effectiveness of local strategic partnerships implemented through local public consultations, and the benefits of upgrading community infrastructure and of citizen mobilization activities. However, despite increased opportunities for participation, the weak involvement of residents in what were judged to be the most important decisions was identified as a weakness of this initiative. The minimal increase in the participation of residents may have been due to a deliberate refusal on their part to collaborate with the public administration.[251] Such scepticism on the part of the population is a factor to consider more closely since it has had a direct impact on the overall reach of the program and its effectiveness in reducing SIH. Moreover, even though the NDC focused primarily on social development through the strengthening of education, projects have been mainly oriented toward economic development.

In Germany, the government chose to target areas with special needs and to implement a management policy for these areas that focuses on social determinants. This policy entitled *Socially Integrative City*[252] seeks to implement ongoing measures and integrated urban development practices in specific sectors based on a holistic approach to revitalization. It relies on the joint effort of three levels of government (federal, national, and local) as well as on support from the European Community and private or charitable partners. The federal government and the provinces co-ordinate the resources and necessary revitalization measures for sectors with special needs.[r] The main objective is to combat the widening of social divisions between neighbourhoods in German cities by stabilizing and improving the physical environment and encouraging cooperation. The population is invited to participate in projects. On the other hand, decision making power is more limited than under the British program. Moreover, the evaluation carried out by the German Institute of Urban Affairs[s] indicates that the majority (about 80%) of revitalization operations are devoted to renovation efforts intended to have a broad beneficial effect on the image and dynamism of targeted areas. The social, cultural and economic dimensions are not explicitly laid out in this program; however the evaluation demonstrates that they are, in fact, integrated into the plans for implementing the projects. The strengthening of social networks and the sustainability of management structures are cited as positive impacts.

Finally the *Health in Neighbourhoods*,[253] strategy, a project stemming from the Neighbourhoods Law (Law 2/2004) of the Catalan government in Spain, is a more recent example of neighbourhood revitalization. Initiated and developed by the department of health, *Health in Neighbourhoods* aims to improve the living conditions of all inhabitants, and particularly those of children, youth, women, the elderly and recent immigrants. The Catalan approach, centered on the involvement of residents, promotes intersectoral cooperation and sustainable actions supported by evidence, as well as by the systematic evaluation of projects.[254] A focus on improving living conditions underlies the active participation of the urban planning, social services and environmental sectors. Evaluation of the project demonstrates that the strategy performed extremely well, as measured by indicators for each of its steps, including the creation of an alliance between a district's residents and stakeholders, the assessment of health needs and, finally, the planning, implementation and evaluation of interventions. Most of the interventions initiated in response to the needs identified by the community affected public services such as schools, sports equipment and facilities, parks and health promotion in the revitalized areas. The citizen involvement permitted within the context of the project helped to strengthen ties within the community and to empower communities to participate in local decision making. The experience of the pilot project districts of Poble Sec and Roquetes led to the project

[q] Evaluated from 2001-2005 through household surveys; analysis of secondary data on school performance, crime and access to government transfers, etc.; annual reports of local organizations.

[r] These areas are identified based on the unemployment rate, life expectancy and the number of persons receiving social assistance.

[s] 2006 evaluation by survey and through discussion groups with local officials.

being extended to all city districts by the Barcelona Sports Institute. It has thus become a source of pride for the people in these disadvantaged neighbourhoods. The synergy between the national Neighbourhoods Law and the *Health in Neighbourhoods* program provided a framework favourable to the revitalization of public spaces and the provision of new equipment, while promoting health and the harmonious coexistence of residents. Although the program reached only a small portion of the population, this included its most vulnerable members. On the other hand, much data is needed to allow measurement of the direct impact on population health.

Housing

Québec interventions

In Québec, the rental market is regulated by, among other laws, the Civil Code of Québec[255] and the Act Respecting the Régie du Logement,[256] which details the obligations and the rights of tenants and owners as regards residential leases, including rent, cost, habitability, comfort and sanitation. The Régie du logement, created by the Act Respecting the Régie du Logement is a specialized court for matters involving residential leases, whose mandate also includes providing information to tenants and landlords.

Social housing is the concern of the Société d'habitation du Québec (SHQ) which coordinates the government actions described in its strategic plan for 2011-2016, the *Plan stratégique SHQ*,[257] which describes a range of SHQ social housing programs[258] available for various low income clienteles. The best known is the *Programme public d'Habitations à loyer modique*[259] (HLM) [public low-rent housing program], funded by the federal and provincial governments as well as by municipalities, which lowers the cost of renting over 63,000 housing units, making them affordable for low-income households.

Other SHQ programs[260] include *AccèsLogis*, *Logement abordable au Québec*, *Allocation-logement*, *Rent Supplement*, *RénoVillage*, *Residential Adaptation Assistance*, *Home Adaptation for Seniors' Independence* and *Renovation Québec*. The SHQ has also produced, along with the Ministère de la Santé et des Services sociaux (MSSS), a reference framework for social housing community support, describing the intersectoral action of the health and social services and housing networks. This document, entitled *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*[261] [reference framework on community support for social housing – Intersectoral action taken by the health and social services and the housing networks], guides the actions of the various actors in the social and community housing sector and in the health and social services network.

With respect to the sanitation of housing units, the Municipal Powers Act[262] (R.S.Q., c. C-47.1) stipulates that any local municipality may adopt by-laws related to sanitation. In cases where regulations are not respected by the owner of a dwelling, recourse must be sought through legal action.

Because of its cost and its inherent characteristics, housing is an important social determinant of health. For low-income individuals, housing-related expenses represent the greater part of their expenditures. Consequently, the underfunding of social housing construction and maintenance, the shortage of affordable housing (especially for families), the absence of a housing allowance, and the inadequacy of rooming house or supervised housing programs all affect people's health and safety. In fact, the WHO devoted the first issue of a series of papers on the social determinants of health to

this subject.[263] According to this international organization, improvement tied to this health determinant would reduce the costs of health services.

The French government views the improvement of private dwellings as one of four factors outside the health system that have a decisive influence on children's health. At the national level, France has made private home improvement a priority and adopted a public policy which aims for the renovation and modernization of private dwellings deemed unfit or extremely run down.[264] The program is managed by the Agence nationale de l'habitat (ANAH), an agency devoted to private housing issues, which also manages a program that combats energy insecurity by improving the energy efficiency of dwellings and helps to humanize places available in shelters. This agency is under the responsibility of the Secrétariat au logement et à l'urbanisme and the Ministère des Finances. Representatives from several other ministries also sit on its executive board (including the ministries of the economy, of the environment, of health and of the interior). The program focuses on the hygiene of premises, the possible presence of toxic products and the safety of sites. In 2009, the ANAH contributed to more 110,000 housing renovation projects (Lopez et al., 2011).[265] One weakness of the program is that only the characteristics of owners are known (age, income, disability, family situation), which does not allow aid for renovations to be granted on the basis of selection criteria that targets tenants instead, such as the presence of young children, vulnerable or very disadvantaged persons. Nevertheless, by targeting unfit housing, which constitutes about 3% of the housing stock (between 400,000 and 600,000 housing units), the project constitutes a promising means of reducing SIH.

In Wales, housing policy is seen as an effective way to combat inequalities which affect a considerable portion of the population (23% of the population lives in low-income households). The national *Homes in Wales*[266] strategy launched in April 2010 focuses on the following priority aims: provide more housing of the right type and offer more choice; improve homes and communities by increasing the energy efficiency of new and existing houses; and improve services and support related to housing, especially for vulnerable people and people from minority groups. The actions to be undertaken are listed in the plan and raise several important questions, including those related to funding. The health benefits of quality housing are explicitly acknowledged by the government and it is seen as going hand in hand with the reduction of social inequalities. In addition, the government has implemented a quality standard *(*the Welsh Housing Quality Standard)[267] which must be met by all owners of social housing. It proved necessary for many small and medium businesses to invest in housing to meet the quality standard. The improvement in quality has also directly benefited tenants who now enjoy safer and more sanitary homes. Social housing is now characterized by lower carbon emissions and better energy efficiency, which means that tenants are spending less for heating. Housing associations and local authorities have demonstrated that the investments made have also produced other benefits. Improving the safety of households (exterior doors, security systems, etc.), for example, as well as improvements to the surrounding land have helped reduce crime and anti-social behaviour. There is also evidence demonstrating the positive effects on the health of tenants, including in particular improved mental health, a reduction in the number of respiratory complaints and fewer visits to generalist physicians.[268]

Transportation and mobility

Québec interventions

The mandate of the Ministère des Transports du Québec (MTQ) [department of transportation] is to ensure the mobility of people throughout Québec by means of safe and effective transportation systems, and to implement paratransit services in order to promote the social, professional and economic integration of persons with disabilities. The *Plan stratégique du MTQ 2008-2012*[269] aims to ensure, throughout Québec, the sustainable mobility of persons and goods by means of safe and effective transportation systems and to make transportation more accessible to persons with reduced mobility. Through its Plans territoriaux de mobilité durable (PTMD) [sustainable mobility plans], the MTQ advocates an integrated approach to transportation planning in association with land development. The new *Stratégie nationale de mobitié durable*[270] is intended to ensure the inclusion of public transit in all significant proposals for land development.

The *Québec Public Transit Policy*[271] is aligned with the government's sustainable development aims and proposes a policy that will benefit the entire Québec population. This policy proposes, among other programs, improved public transportation services, a government assistance program to support public transportation in rural areas and a subsidy program for the adaptation of taxis.

The *Bicycle Policy*[272] promotes cycling as "a mode of green transportation that encourages active transportation, a healthy lifestyle, the reduction of greenhouse gas emissions and the economic, tourism and sustainable development of the regions."

The aim of the *Programme d'aide gouvernementale au transport adapté aux personnes handicapées*[273] [government assistance program for adapted transportation for persons with disabilities] is to provide financial support to public transit authorities as well as to municipal organizations that wish to develop transportation services that meet the needs of persons with disabilities.

As with housing policies, transportation policies can have positive or negative effects on health. The *Charter on transport, environment and health* adopted by WHO-Europe[274] sets out principles and strategies for developing transportation policies compatible with health and the preservation of the environment. It recommends integrating health impact assessment (HIA) into the approval procedures for major road infrastructure projects and adopting transportation plans that encourage public and active transportation. The WHO favours interventions that promote social equity, ensure that public transportation is accessible to persons with disabilities, prioritize non-polluting modes of transportation, isolate transportation networks for non-motorized vehicles, improve vehicle standards and technology, make use of economic instruments (taxes, tax credits, tolls, etc.) and promote road safety.

Transportation plans which provide more space for non-motorised transportation counter the negative impacts (climate change, air quality, traffic) of transportation, which primarily affect disadvantaged populations. In the Netherlands, cycling was promoted through planning policies that have been encouraging the use of two-wheeled non-motorized transportation for more than thirty years. Thus in 2010, the modal share of cycling had reached 26% nationally and over 30% in Amsterdam. Since 1990, in accordance with the national bicycle plan (*The Dutch Bicycle Master Plan*),[275] implemented by the Ministry of Transport, a significant portion of the budget has been invested in facilities and campaigns that encourage cycling. This mode of travel has emerged as a way to both fight climate change and to improve accessibility in cities while helping to reduce the

negative effects of inactivity and motorized traffic. Evaluation of the policy's implementation[276] indicates that it has had an impact on bicycle use, which has increased markedly, especially in more densely populated areas and in urban agglomerations. Similarly, in Denmark, the national transportation policy greatly increased the popularity of walking and cycling.[277] In 2008, 16% of trips were made by bicycle in this country.[278] In Copenhagen, the bicycle is used daily by more than one in three commuters. In this city, cycling is seen as a fast and convenient means of transportation.[t] Moreover, urban planning and infrastructure (bike paths, bike parking and passageways to circumvent obstacles) help make this a safe means of transportation.[279] In 2009, authorities undertook to finance facilities enabling bicycle "commuting" between communities by earmarking specific funding for cycling in the national transportation budget. Although these initiatives promoting cycling increase the overall accessibility of an alternative, less expensive mode of transportation, the impact of such measures on SIH remains difficult to measure.

National policies that support municipal governance and citizen participation can also have significant benefits related to mobility. Colombia offers a good example. The 1991 Constitution provided municipalities more freedom in the areas of political, administrative and fiscal management, through a process of decentralization and local skills development. This country's constitution requires that each locality produce its own participatory local development plan (*Plan de desarrollo local participativo*) identifying the region's priorities. The success of major transportation projects such as *TransMilenio*[280] (the bus rapid transit (BRT) network) and *Ciclo-Rutas*[281] (bicycle paths), implemented in Bogota, demonstrate how much impact strong local political will can have and just how important public-private partnerships are to the development of an innovative, more equitable and greener transportation network. Moreover, inviting citizens to participate in the decision-making process secured their support for measures such as reducing car use and favouring alternative modes of travel. These interventions, in addition to reducing pollution and traffic congestion in the capital, encouraged greater respect for public property, increased citizen participation in matters of civic order, strengthened the standards, values and rules of community life, led to better recognition of individual and collective rights and awakened a sense of identity and of belonging in the city and in neighbourhoods.[282]

Key points regarding the land use planning determinant

Overall, means for intervening in SIH through territorial development are numerous and diverse (sustainable development plans, social housing, laws concerning sanitation, development of alternative modes of transportation, etc.). 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—those 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.

[t] In a poll conducted in 2006, 54% of cyclists in Copenhagen said they use a bicycle because it represents a fast and convenient way to travel in the city. On the other hand, 19% cycle because it allows them to be physically active and only 1% cycle for environmental reasons.

4.4 Lifestyle

Lifestyle choices—whether linked to food, physical exercise, use of tobacco, alcohol or other drugs that may lead to addiction, 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 correlate to 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, are not necessarily more prevalent among 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 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.[283] 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 of reaching the most disadvantaged segments of the population.[284] 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, in collaboration with seven other departments and three government agencies, is responsible for developing the PAG (*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),*[285] an action plan to promote healthy lifestyles and prevent weight-related problems. The PAG is intended to promote a healthy diet and a physically active lifestyle.

Since June 2006, the Act to Establish the Sports and Physical Activity Development Fund[286] has facilitated the practice of physical activities and contributed to the development of a sports culture within the Québec population. The fund provides municipalities, academic institutions and not-for-profit organizations with financial support for the construction, renovation, planning and upgrading of sports and recreational facilities.

The *Kino-Québec*[287] program, established in all Québec regions since 1978, also seeks to promote physically active lifestyles to contribute to the well-being of the Québec population. This program is managed jointly by the MELS, the MSSS and the health and social services agencies.

Since 1997, an educational childcare program[288] offered throughout the province includes prevention and promotion activities intended to provide children with an environment that encourages the acquisition of healthy eating, living and behavioural habits.

The above programs are intended for the general population and are not proportionately targeted to vulnerable groups, even though the *Québec Public Health Program* identifies the fight against SIH as a priority. The contribution of these programs to reducing social inequalities in health has not been demonstrated.

At the international level, in 2004, the WHO launched the *Global Strategy on Diet, Physical Activity and Health*[289] to support interventions that effectively enable people to live longer and in better health, reduce inequalities and promote development. By involving all sectors, including civil society, the media and the private sector, this strategy aims to create conditions conducive to the implementation of sustainable measures at all levels, individual, community, national and worldwide that promote healthy eating and physical activity. This strategy is supplemented by *A Framework to Monitor and Evaluate Implementation*[290] to assist countries that implement the strategy. However, it is the *European Charter on Counteracting Obesity*,[291] adopted by WHO-Europe in 2006, that explicitly acknowledges the constraints which hamper the ability of disadvantaged groups to adopt healthy eating habits. This same document proposes making the economic accessibility of healthy foods a priority. The Charter also proposes, among other things, supporting programs that distribute free fruit to schools, keeping healthy foods affordable and improving access to these foods within workplaces and in disadvantaged communities.

In 2006, the Nordic Council of Ministers, composed of representatives from the Nordic governments of Europe, adopted the *Nordic Plan of Action on better health and quality of life through diet and physical activity*[292] which is based on the principle of health equity and supports interventions that specifically target vulnerable and at-risk groups. One of the objectives of this plan is to limit variations between different socioeconomic groups with regard to diet, exercise and obesity to less than 20%. An initial evaluation[293] of this plan indicates that these variations between different groups do not appear to be as marked a priori as assumed; however, researchers are questioning whether the evaluation succeeded in reaching the most vulnerable persons. This evaluation also indicates that some of the action plan's targets for improvement would be difficult to reach, such as the goal for sufficient intake of fruits and vegetables or the aimed for increase in physical activity among children, while others such as the desired decrease in trans fat consumption appear more realistic. Scandinavian countries have been actively promoting healthy lifestyles for many years. Finland is well-known for its successful interventions of this nature, such as the *North Karelia Project*,[294] for example, implemented in the early 1970s, which has helped to create more homogeneous dietary habits across different socioeconomic groups. More recently, in 2008, the Finnish government launched an intersectoral program, the *Government Policy Decisions on Healthy Diet and Physical Activity*,[295] which includes an action plan focused specifically on the reduction of SIH related to health promotion.[296]

In addition, promising initiatives are emerging in countries that have recently joined the EU. In 1994, the Czech government implemented *HealthProEldery*,[297] a program promoting healthy lifestyles that specifically targets seniors. Managed by the Ministry of health and involving municipalities and community and religious organizations, this program supports health promoting activities, such as sporting activities, conferences, social networking and home support. A therapeutic dance program for seniors that includes people with Alzheimer's and dementia, the initiative of a renowned Czech ballet dancer, has been highly successful.

Another inspiring project was developed by the Slovenian government. The *MURA*[298] project relies not only on public health authorities in the community of Pomurje, a region known to be the most disadvantaged in the country, but also on the agri-food and tourism industries to coordinate measures that foster economic development and population health. The agri-food industry contributes by helping ensure the quality and safety of food products from farm to table, by producing more fruits and vegetables, and by promoting sustainable production methods and short supply chains. A consortium of fruit and vegetable producers and ecological support centres for organic agriculture were created in 2004. The tourism industry, for its part, focuses on the development of ecotourism infrastructure and on the promotion of healthy food products and

recreational activities. This project supports activities that promote healthy eating and physical activity among local populations, schools and marginal groups. In addition, to capitalize on the popularity of thermal spas in this region, the industry put effort into making it a popular destination for walking and cycling enthusiasts. An initial evaluation of the impact of this program in 2004 showed a concrete impact on the health of the population, which was eating better and was more active.

Food and food security

Québec interventions

The MSSS's *Cadre de référence en matière de sécurité alimentaire*,[299] a reference framework for food security, is aimed at promoting concerted collective action on the key environmental and individual determinants of food security. It aims primarily to improve physical and economic access to healthy food for people living in poverty, through activities promoting food self-sufficiency and food relief.

Certain factors may prevent the adoption of healthy eating habits. For example, the nutrient intake of individuals is sensitive to fluctuations in financial resources. Thus, WHO-Europe recognizes the importance of the link between food and poverty in its *First Action Plan for Food and Nutrition Policy 2000-2005*[300] whose aim is to "ensure optimal health, especially in low-income groups and during critical periods throughout life." This plan offers a model that allows for the integration of social and economic variables when the goal is to intervene in the behaviour of individuals.

The *Norwegian Action Plan on Nutrition (2007-2011) – "Recipe for a healthier diet"*[301] directly targets the reduction of social inequalities in eating habits. This plan proposes the implementation of interventions in several environments, including schools, workplaces and health care institutions. This plan includes, among other proposals, subsidized and low-cost access to healthy meals in schools and daycare centres. Another intervention consists in adapting nutritional information to different groups defined by gender, age, social status and ethnicity. Twelve departments collaborated on the development of this action plan and they share responsibility for implementing the measures selected.[302]

To improve access to healthy food, British health authorities introduced, in 2000, a program for distributing fruit and vegetables in schools, the *National School Fruit Scheme*,[303] funded by lottery revenues. The United States also implemented the *Federal Fruit and Vegetable Program*[304] in 2002 to allow targeted primary schools, especially those operating in disadvantaged areas, to obtain subsidies for the purchase of fruits and vegetables. In fact, although this strategy seems promising, the U.S. government generally uses its surplus of agricultural products that would be lost by redistributing them, often without regard to their nutritional quality or to a food plan targeting needy populations.[305]

The United Kingdom has also implemented a policy aimed at reducing food-related inequalities, the Food Poverty Eradication Bill.[306] One of the bill's measures is to eliminate food deserts by increasing access to good quality food in certain disadvantaged neighbourhoods. Two supermarkets were opened up in disadvantaged neighbourhoods. A study of the impact of this measure reported a noticeable improvement in the diet of residents.[307]

Tobacco, alcohol, drugs, other substances and gambling

Québec interventions

Under the Tobacco Act[308] 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 the regulations 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*,[309] a plan for preventing teen smoking, are to prevent people from starting to smoke, to help smokers 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*,[310] an inter-departmental action plan on substance addiction. This plan focuses on prevention, early intervention, treatment and social reintegration.

These interventions are not specifically focused on reducing social inequalities in health, even though some are designed to reach vulnerable population groups.

Addiction to tobacco, to alcohol, to gambling or to other substances are matters of great complexity and most governments choose to address such issues through policies that focus on these issues separately. However, Australia has developed the *National Drug Strategy 2010–2015*,[311] which is a global framework for action on alcohol, tobacco and other drugs involving all levels of government, the non-governmental sector and communities. One of the pillars of this policy is its support for efforts to promote social inclusion and resilient individuals, families and communities by adopting a harm reduction approach. This strategy was implemented in 1989 in Australia and its last evaluation,[312] which dates back to 2009 notes the importance of paying greater attention to health determinants and of developing policies and programs focused on the prevention of drug-related problems.

The *WHO Framework Convention on Tobacco Control*[313] took effect in 2005. Its objectives are to reduce the number of smokers in the world and to limit environmental exposure to second-hand smoke. This convention has been ratified by more than 140 countries and includes interventions affecting the sale and advertising of tobacco products and anti-smuggling measures. It proposes interventions targeting the entire population and does not specifically aim for the reduction of inequalities or target disadvantaged populations. Note, however, that various tobacco control interventions can have differing effects on SIH(314). Indeed, broad media campaigns and the prohibition of smoking in the workplace can be more effective among advantaged groups and thereby increase SIH, whereas price increases and tax measures are more effective among disadvantaged groups and may reduce SIH. Other approaches, like warnings on packages, appear to be neutral with respect to SIH. [314]

Between 2005 and 2010, the European Union applied its anti-smoking campaign *HELP – For a Life Without Tobacco*,[315] which targeted young people from 15 to 25 years old and focused on smoking prevention and cessation assistance. The evaluation[316] of this prevention-based media campaign revealed significant results, with massive numbers of young Europeans having been reached.

According to the World Bank,[317] one of the most promising interventions in terms of cost-effectiveness for reducing smoking, especially among young people and disadvantaged groups, is to increase the sale price of tobacco products. Several countries have applied this measure with

impressive results, including the United States, Australia, New Zealand, France and Canada. Thus, a 10% price increase led to a 4% decrease in consumption in wealthy countries. Some countries, such as Australia and New Zealand, reinvest some of the revenues from price increases in smoking prevention strategies.

The United Kingdom has developed interventions targeting this problem[318] within the context of its global strategy[319] for combating inequalities described above. Several tobacco use reduction strategies were developed by this government specifically targeting low income groups. The evaluation[320] of these interventions carried out in 2007 showed that the prevalence of smoking had decreased, but that differences between socioeconomic groups had not. Even though smoking cessation programs aimed specifically at disadvantaged groups appear to be more effective than ever, they do not seem to contribute substantially to the reduction of SIH.

New Zealand launched a strategic plan to reduce the harmful effects of gambling, the *Preventing and Minimising Gambling Harm: Six-year strategic plan 2010/11— 2015/16*.[321] The primary objective of this plan is to specifically target the reduction of 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. The plan is directed by the Ministry of Health.

Key points regarding the lifestyle determinant

Stemming from either an environment-based approach or an approach focused on changing individual behaviours, the interventions (in Québec and globally) presented herein involve 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. According to a report by the INSPQ[322] : "Programs and policies that promote healthy eating must take into account the socioeconomic conditions of various groups within the population, in particular those of low-income households. Monitoring the prices of healthy foods and disseminating this information could help guide households living under precarious financial conditions" [translation]. 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 targeting disadvantaged neighbourhoods, such as Slovenia's *MURA Project* or Finland's *North Karelia Project*, produced noteworthy results. These targeted approaches make it possible to reach 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 encourage the mobilization of actors around shared priorities for action.[323]

4.5 Health care and health services systems

Universality, socialization, equity, and quality health care and health services help to prevent further entrenchment of SIH. Access to health care and services, in other words the ability to obtain health services that meet a need or a desire for care, is particularly important given that studies in Europe indicate 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.[324] [325] [326] Access to care can be limited by several factors related to socioeconomic status, as well as 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*[327] (RAMQ) entitles all residents of Québec to 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 receiving social assistance or welfare benefits for at least one year. Another universal public plan, the Hospital Insurance Plan,[328] provides free access to hospital services. Finally, the *Public Prescription Drug Insurance Plan*[329] is intended for persons who do not have private insurance that covers medication costs.

In France, universal health coverage protects the population from the main costs associated with potential illness. An Act passed on July 27, 1999 established a system of universal health care coverage, the Couverture maladie universelle or CMU, which 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, universal access to care remains a challenge. In 2004, 13% of the French population denied themselves medical care (dental services, eyeglasses or other specialized care) for financial reasons.[330] 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.[331]

Although, in theory, care and services covered by public programs are equitable, in practice the reality proves more complex. In fact, vulnerable populations are often the first to be affected by a scarcity of services or cuts to health care funding. Dental care and mental health services, whose coverage is limited, offer a good example of how established policies do not necessarily prioritize the needs of the most disadvantaged. 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 to make the least use of these services.

Care organization and access

Québec interventions

The organizational model described in the Act Respecting Health Services and Social Services (AHSS)[332] is structured around three levels of government—central, regional and local—and complementarity between institutions. At the local level, the local service networks unite all health and social services actors under one institution called a Centre de santé et de services sociaux (CSSS).[333] A CSSS must not only ensure the provision of health and social services, but also mobilize other partners within its territory, such as community organizations, social economy enterprises and partners from the education and municipal sectors, in order to improve the services offered and to act on the determinants of health affecting its population.

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 referred to as "population-based responsibility."

The mission of the Health and Welfare Commissioner[334] 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,[335] on perinatal and early childhood services[336] and on mental health services,[337] among others, outline recommendations for better access to services for disadvantaged groups.

Care and services may be organized in various ways to improve access for the most vulnerable. For example, the aging of the population in the West has led several countries to adapt services to the specific needs of this population. In 2001, the United Kingdom implemented the *National Service Framework for Older People*.[338] This policy is aimed at providing older people with fair, reasonable access to integrated health care and social services. The framework 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 evaluative survey 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.[339] The experience of this reform demonstrates that professional and specialized expertise is crucial to achieving the policy's objectives. The *LinkAgePlus*[340] pilot program and the *Partnerships for Older People*[341] projects helped extend more widely a collaborative approach to improving access to care for older people. Research into geriatric medicine is considered essential to understanding the experience of older people and tailoring services to their needs.

Despite the modest results reported thus far, the integration of mental health care with primary health care services represents another avenue that may mitigate SIH. It is well-recognised that care for people suffering from such problems is generally underfunded.[342] The stigmatization of people with mental health disorders is also a major obstacle preventing many people from seeking care and services. Research shows that there are several advantages to undertaking a holistic approach to mental and physical health, particularly in terms of accessibility and funding.[343] Over the last 20 years, the government of 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 brought forward the strategy *No health without mental health: a cross-government mental health outcomes strategy for people of all ages*.[344] One of this strategy's direct objectives is to improve accessibility to mental health services and care for all. Moreover, each objective outlined in this strategy was assessed in terms of its impact on equity[345] for different population groups (defined according to age, gender, ethnic origin, sexual orientation, etc.).

Strengthening health competencies within communities

Québec interventions

A 100-hour health training program is integral to the *Politique gouvernementale d'éducation des adultes et de formation continue*,[346] a government policy on adult education and continuing education and training, directed by the MELS which targets vulnerable clients, among others. 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 condition, recreation, or recovery.

The development and strengthening of health literacy skills are an important factor in combating SIH: a lower level of health literacy is associated not only with poorer health, but also with lower income and lower quality of life.[347] The people most affected are seniors, people with little education and immigrants. In Germany, the MiMi program (*With Migrants for Migrants*)[348] is aimed at making the health system more accessible to immigrants by increasing their health literacy and building general capacity within communities that relates to 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. The exchange of knowledge about how the health system functions and how to access resources is carried out through intercultural mediators from the community who are trained to work with immigrants. In addition, health care professionals are encouraged to themselves acquire knowledge about various communities to better understand the challenges they face. The program was initially launched as a pilot project in four German cities and has now been extended to 48 municipalities. The evaluations conducted among program participants show a marked increase in the number of immigrants who accessed health care and services (1105 in 2004 versus 7441 in 2008). Moreover, the annual reports published since 2007 indicate that the program has contributed to the building of close ties between immigrant communities and the healthcare system.[349 350] More broadly, studies have shown that community and participatory approaches are promising avenues given the presence of low levels of health literacy.[351 352]

Key points regarding the health care and health services determinant

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. Programs such as the MiMi project in Germany stimulate reflection on how to respond in new ways to constantly evolving 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. However, according to data from the International Adult Literacy and Skills

Survey, 95% of the Québec population over 65 years old fall below the minimum level of health literacy required to adequately care for their health.[353] Partnerships between departments (MSSS, MELS, MESS) in the areas of literacy and health for targeted populations are among measures worth exploring.

Key points regarding government interventions focused on determinants

The determinant-based interventions outlined in this section emanated from a number of sectors, including that of health. Many of these interventions, such as revenue support or municipality revitalization measures, do not focus primarily on SIH or on health. Some measures focus on prosperity or economic development, and can have an indirect impact on SIH and on health. Several interventions based on approaches focused on the living environment, such as community development, affect several determinants and are considered to be intersectoral projects.

This overview underscores the fact that political mobilization is crucial to the success of the interventions adopted. 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, provided the interventions adopted focus on social dimensions and not only on environmental protection. Intersectoral projects focused on economic development, such as Slovenia's *MURA* program (health, agri-food, tourism, and transportation), have resulted in positive benefits for disadvantaged populations.

Several foreign initiatives also 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 precarious or hazardous to health or building low-quality social housing will do little to reduce SIH or improve health. With respect to housing, the quality standards for social housing in Wales have been demonstrably shown to improve the physical and mental health of tenants. With regard to access to health services, even though most of the countries discussed, have, like Québec, adopted universal coverage of health services, this coverage fails to provide for certain people in irregular situations (the homeless, illegal immigrants, etc.) or to include coverage of certain services. In the early childhood sector, foreign experiences also show that the quality of daycare services and of interventions targeting disadvantaged children is crucial.

In addition to the quality of interventions, it seems that the integration of services is often necessary to ensure they are accessible to the most disadvantaged populations. This is the case particularly for health services (for example, the integration of primary health and mental health services) and early childhood services. Coordination of the different services intended for vulnerable persons is paramount to ensuring their participation in these interventions.

Finally, two challenges appear to be associated with interventions targeting health determinants, 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 make less use of public services, even when they 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.

Conclusion

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. Their adoption and implementation are facilitated by 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 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(13), are avenues to be promoted. Moreover, the mobilization of different actors around shared priorities for action, citizen participation in interventions, high quality interventions, and the integration of services to enhance their accessibility represent other conditions likely to ensure successful, effective implementation of these measures.

However, attempts to combat 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.[354] 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(15). Prescription 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(109). Québec has also performed well with regard to healthy lifestyle interventions, although the latter contribute very minimally to reducing SIH. Government maintenance and strengthening of sustained interventions in the areas of social protection and health remains 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 negating 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; the *Government Sustainable Development Strategy*; a community development strategy; health impact assessment processes; and 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 provide quite useful guidance.

In addition, involving 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 carried out by the Commission on Social Determinants of Health, the World Health Organization (2011)[355] recommends that countries seeking to steer development along a path toward health equity should, at the very least, implement a system for systematically evaluating social inequalities in health. 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 health inequities. Québec recently demonstrated a commitment to pursuing this avenue by conducting a reflective review process involving provincial 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.[356] Finally, knowledge development and scientific monitoring of the effectiveness of government interventions at reducing SIH would help guide the government through the process of selecting and reviewing its interventions.

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, although some authors recommend prioritizing 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 implemented in conjunction with interventions 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 social inequalities in health by exploring the policy avenues proposed here and enhancing its policies in light of the multiple examples presented in this document.

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