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CHAPTER 12

Moving Beyond Health in All Policies: Exploring How Policy Could Front and Centre the Reduction of Social Inequities in Health

Ditte Heering Holt and Katherine L. Frohlich

1 Introduction

In recent years, there has been a proliferation of concepts to understand how best to enact intersectoral health policies. Much of this work is specifically focused on the promise of Health in All Policies (HiAP), an intersectoral approach to public policy that seeks to promote action on

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the Social Determinants of Health (SDH).[1] Indeed, the rapprochement of HiAP and the SDH has been viewed to be an intervention solution to reducing social inequities in health (Baum, Lawless, et al., 2013; Marmot, 2010). In practice, however, questions of health equity are often marginal in these discussions and not apparent when evaluating outcomes (Baum et al., 2017; Hall & Jacobson, 2018; Khayatzadeh-Mahani et al., 2019; van Eyk et al., 2017). Additionally, several scholars have demonstrated how governments, though paying lip service to the social determinants of health to reduce social inequities in health, often enact policies that are best described as a lifestyle drift (Fisher et al., 2017; Lynch, 2017; Smith, 2013). In this paper we develop the argument that as a policy framework, the ways in which HiAP is undertaken are insufficient to achieve reductions in social inequities in health and may even worsen them. In doing so, we believe we are demonstrating what, in practice, a political science *with* public health might look like. As discussed in Chapter 2 (Fafard et al., 2022), this involves a critical and conceptually sophisticated perspective that interrogates the inherent assumptions of public health practice while remaining sympathetic to the broader public health project.

This paper begins by discussing the distinctions between the concepts of public health policy (PHP), healthy public policy (HPP) and HiAP. We demonstrate, firstly, that the substantive concerns of these approaches differ greatly and that the blurring between these concepts may lead to inefficient public health advocacy and policy efforts. Building on this discussion, we develop a conceptual critique of HiAP that distinguishes problems of intentionality and directionality. We argue that for public policy to effectively reduce social inequities in health, it should focus desired change away from any one health issue in isolation, towards the drivers of the inequities. In order to effectively do so, new policy approaches would have to emphasize the sectoral contribution of non-health sectors. These arguments serve to clarify the disparate approaches included in the "umbrella" concept of HiAP.

As an empirical example throughout this paper, we use the last 30 years of tobacco control (as well as HiAP policy more broadly) to assist in making our point. Many would claim that tobacco control policy has been one of, if not the single-most effective public health policy in the history of modern public health. It is also highlighted as a prime example

[1] See Chapter 11 by Cairney et al. (2022) in this volume for a complimentary critique of HiAP.

of the need for, and potential success of, a HiAP approach. As Bettcher and Silva phrase it: "Tobacco control programmes are an example of the application of the HiAP concept as they already permeate the agendas of different sectors in different governments, resulting in a concentrated effort to improve population health" (2013, p. 203). We discuss the ways in which tobacco control policy to date does or does not fulfil the objectives of HiAP.

To conclude the paper, we draw on Amartya Sen's capability theory (1992) to develop the argument that public policy concerned with inequity in health must focus on the inequity in lack of opportunity that some may have to achieve good health due to inadequate social arrangements. We believe the use of Sen's theory may go some way to ensure that overcoming social inequities remains the focus of intersectoral policy interventions.

2 Public Health Policy, Healthy Public Policy, and HiAP

To begin to understand HiAP's shortcomings with reference to health inequity reduction, a brief historical and definitional foray into the differences between public health concepts regarding intersectoral policy approaches is necessary. We start by defining how we use the concepts of *public health policy (PHP)*, *healthy public policy (HPP)* and *HiAP* in order to clearly distinguish the implications of these different policy frameworks on equity outcomes.

Public health policy (PHP) is often used as a broad concept encompassing the total sum of policies and programmes put in place to advance public health goals. However, for the purpose of conceptual clarity, we use public health policy (PHP) more specifically to circumscribe the good number of policies concerned with "health problems" based primarily on a biomedical model (de Leeuw et al., 2013). This type of PHP is often designed to change health behaviour, either directly or indirectly, by making "unhealthy choices" less attractive. They may be directed at a structural level by changing the environment or at an individual level, but their emphasis is to reduce risk and prevent disease (Chaufan et al., 2014; Lorenc et al., 2013). Often these public health policies (PHPs) include intersectoral action. For example, in the case of tobacco control policy, justice departments have become involved to develop and enforce bans on certain kinds of tobacco products, and departments of finance

have been asked to develop and implement fiscal policies that raise the price of tobacco products and thereby reduce demand. The end goal and focus of the policy, however, is to reduce the prevalence of risk factors in a population by acting on the risk factor or health behaviour itself (i.e., the reduction of cigarette smoking). There is, therefore, no intersectoral goal beyond the reduction in the prevalence of the health problem alone (tobacco smoking). As such, this kind of public health policy is characterized by a sectoral aim of better health and involves intersectoral action only to achieve this relatively narrow goal, with little or no attention to broader questions of health equity.

By contrast, we understand *healthy public policy* (HPP) to encompass policies concerned with the conditions that create a healthy society (Hancock, 1985). HPPs are based on a social model which views health to be influenced by a multitude of social, environmental, political and economic factors, often referred to as the *social* determinants of health (SDH) (Commission on Social Determinants of Health [CSDH], 2008). The concept of healthy public policy was first promoted by Nancy Milio (Milio, 1981). The Ottawa Charter for health promotion embraced the concept and argued that HPPs combine "diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity" (World Health Organization [WHO], 1986). In other words, HPPs are public policies that involve upstream interventions with social equity as one of their goals (Oneka et al., 2017).

In contrast to public health policies, HPPs have an intersectoral aim (i.e., creating a healthy and equal society) which requires coordinated sectoral action. Examples of HPPs include, among others: giving every child the best start in life; improving education and lifelong learning; ensuring employment and good working conditions, providing a minimum income for healthy living, and healthy and sustainable communities (Marmot & Allen, 2013, p. 75). While the concept of HPP underscores the importance of coordinated policy action across sectors to achieve health equity, it has provided little guidance on how to achieve policy change in practice (de Leeuw & Clavier, 2011), and there is still little evidence on the success or failure of HPP in reducing social inequities in health through intersectoral policymaking (de Leeuw, 2017).

Since the mid-2000s, the notion of *Health in All Policies* (HiAP) has gained strong support in the public health community as a further

innovation of HPP, and largely to overcome the lack of policy change provided by HPP (Baum, Lawless, et al., 2013; de Leeuw, 2015; de Leeuw et al., 2014; Kickbusch & Buckett, 2010; McQueen et al., 2012; Ollila, 2011). HiAP is often defined as: "an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity" (WHO, 2013). While some use HiAP interchangeably with HPP, HiAP is more often referred to as an approach (WHO, 2013, among many others), a strategy (Freiler et al., 2013; Rudolph et al., 2013), a mechanism (Baum, Ollila, et al., 2013), or a policy practice (McQueen et al., 2012), for achieving the goal of HPP (Baum, Ollila, et al., 2013). HiAP is usually understood to place a stronger emphasis on health governance than HPP does to ensure intersectoral engagement and collaboration. It also generally involves a centralized and systematic approach to considering the health effects of (all government) policies using health impact assessments or similar arrangements (Baum et al., 2014; Freiler et al., 2013; Ollila et al., 2013). While specific HiAP examples differ in terms of both governance and priorities, reflecting their local contexts, HiAP may be considered an approach that involves introducing a set of institutional arrangements to break down institutional barriers to collaboration and ensure intersectoral policymaking for better health. Carey et al. (2014) conceptualize HiAP as an instrumental process-based intervention. This means that HiAP is not understood to be inherently able to improve health as such. Instead HiAP introduces new governance structures and decision-making processes which should be instrumental in creating healthier policies (Baum et al., 2014; Carey et al., 2014; Freiler et al., 2013). Other researchers have emphasized the importance of the broader policy process to affect the uptake of HiAP and promote the use of political theory to qualify intersectoral policymaking for health (Clavier & de Leeuw, 2013; de Leeuw & Peters, 2015; Rashad & Khadr, 2014; WHO, 2015, see Chapter 11, by Cairney et al., 2022 as well). A well-recognized example of HiAP is found in South Australia (Baum, Ollila, et al., 2013) where a health lens analysis was introduced together with a dedicated HiAP unit. HiAP was supported by a mandate linked to the State Strategic Plan which was formally endorsed by Cabinet (Baum et al., 2017).

For the purpose of conceptual clarity, we thus understand HiAP to involve a change in focus from the two previous concepts. As outlined in Table 1, we use PHP and HPP as analytical concepts that circumscribe

Table 1 Definitions

Concept	*Focus*	*Definition*
Public Health Policy (PHP)	Analytical concept Circumscribing the content of policy	PHPs are concerned with health problems based primarily on biomedical determinants of health model PHPs focus on changing behaviours, reducing risk factors and preventing disease PHPs utilize individual and/or structural interventions PHPs are characterized by a sectoral health aim and intersectoral action
Healthy Public Policy (HPP)	Analytical concept Circumscribing the content of policy	HPPs are concerned with the conditions that create a healthy and equal society HPPs are based on a model of the social determinants of health HPPs entail upstream policies that support health, well-being and equity HPPs are characterized by an intersectoral aim and coordinated sectoral action
Health in All Policies (HiAP)	Approach to policymaking	HiAP is an approach to policymaking across sectors that takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts HiAP involves introducing institutional arrangements to facilitate intersectoral policymaking HiAP seeks to improve population health and health equity

end goals regarding the content of public policies. The question of their implementation is a question directed at the content of specific public policies. The question of HiAP implementation, on the other hand, refers to the introduction of health governance and decision-processes to create intersectoral policymaking for health (equity).

These definitions highlight how the substantive concerns of these three health policy concepts differ in important ways. The first two differ in terms of the content of their policy focus, and consequently their intersectoral aspirations as well as their ability to tackle inequities. HiAP differs from both of the others by focusing on the mechanisms to bring about policy change (rather than the policy content alone). However, HiAP is also routinely used synonymously with the other two, particularly HPP, which blurs the distinction between policy content and approach (Kickbusch, 2013; Ståhl, 2018).

There have been previous attempts to clarify the distinction between PHP, HPP and HiAP (Storm et al., 2007 referenced in den Broeder et al., 2015; de Leeuw et al., 2013, 2014), as well as attempts to outline the different conceptualizations of HiAP, as synonymous with HPP or as an approach involving a set of institutional arrangements (Carey et al., 2014). However, as we argue here, HiAP has at least two further shortcomings with regard to its ability to be a motor for change when concerned specifically with social inequities in health. First, the discourse on HiAP equates policies for improving population health with those concerning health equity (what we will call intentionality). Second, the discourse on HiAP lacks clarity regarding whether health is its main objective or whether health is simply part of a broader societal goal. Accordingly, this leads to confusion about the expected contribution of non-health sectors to HiAP (what we will call directionality) which, in turn, risks making public health advocacy misguided and, subsequently, the intersectoral engagement ineffective.

3 HiAP's Confused Intentionality and Ambiguous Directionality

As outlined above, a significant part of the HiAP literature argues for changes in the ways in which governments engage in intersectoral collaboration as much as it argues for changes to policy content. To ensure conceptual clarity, we use the terminology of PHP and HPP below when we refer to specific variations in HiAP policy content.

We use intentionality to refer to the (implicit or explicit) policy intention to address social inequity in health when discussing the content of HiAP policies. Taking inspiration from Bacchi's (2009) "What's the problem represented to be", intentionality involves the policy analytical question of how HiAP policies explicate how they will address social inequity in health.

By directionality we refer to the aim and scope of HiAP engagement. Directionality involves the analytical question of how HiAP constructs the role and contribution of health and non-health sectors in achieving the goal of reducing social inequities in health.

3.1 Confused Intentionality: The Shortcomings of HiAP to Address Social Inequity in Health

The first criticism of HiAP with regard to its ability to tackle social inequity in health relates to its approach to policy content, or more specifically, the ambiguity that ensues from its dual aim of both promoting population health and reducing social inequity in health (WHO, 2013). This reflects the dual meaning of the social determinants of health (SDH) as identified by Hilary Graham (2004, 2009): targeting both the social causes of health and the social factors determining the distribution of these causes. The former encompasses health promoting or impairing resources found in the social and material environments for example, the home, neighbourhood and workplace. The latter refers to the distribution of societal-level resources like income and wealth, education, employment opportunities, political influence and power, which shape access and exposure to the social determinants of health (Graham, 2004, pp. 107–108). As such, the social determinants of health are not to be conflated with the social determinants of health inequity (Baum, 2016). A case in point is observed in many Western high-income countries where both living standards and population health have significantly improved over the past 50 years. Yet, at the same time, health inequities have persisted and even increased in some cases (Graham, 2004; Mackenbach, 2012; Mackenbach et al., 2015). Nonetheless, this confusion appears to often be the case in health impact assessments which struggle to include macro-economic policy as a determinant (Buse et al., 2019; Povall et al., 2013).

Despite the honourable intention of tackling the twin challenges of reducing ill health at a population level and diminishing social inequities in health, the blurring between the two perpetuates the assumption that

social inequities in health can be reduced by policies focusing only on the social determinants of health. This tends to give prominence to population health concerns rather than equity in HiAP-inspired policymaking (Graham, 2004; Kvåle et al., 2020; van Eyk et al., 2017) and is made even more likely given the difficulties in "selling" the re-distribution requirements that social equity policies demand.

This shortcoming is partly due to (or justified by) the assumption that action on the SDH will "trickle down"; overall improvements in SDH are expected to reduce social inequities in health over time (van Eyk et al., 2017). According to this logic, for instance, policies focused on reducing smoking prevalence at a population level should in turn reduce social inequities in smoking because the prevalence of smoking is highest among lower SES-groups. However, this logic constitutes what we would define as a health drift: a displacement where the intention of HiAP to address social inequity in health translates as more limited PHPs addressing only intermediary SDH, if not just the risk factor itself (Graham, 2009).

One such example is the Scottish tobacco control policy *Creating a Tobacco-Free Generation: A Tobacco Control Strategy for Scotland*, which sets itself apart from other countries' tobacco control policies by having a distinct focus on inequities (Healthier Scotland, 2013). This comprehensive and ambitious policy aims to reduce smoking prevalence to 5% or less by the year 2034. Moreover, it distinguishes itself from those of many countries because it aims specifically to reduce stark social inequities in smoking in Scotland.

However, rather than focusing on the social determinants of health inequities in the policy, smoking is considered to be a crucial contributing cause of health inequities. As phrased in the document:

> the patterns of smoking prevalence rates [...] are a very direct cause of Scotland's continuing health inequalities. It therefore follows that reducing smoking prevalence rates in the most deprived communities will make a decisive contribution to reducing Scotland's health inequalities. (Healthier Scotland 2013, p. 7)

Although underlying environmental and living conditions (e.g., built environment, income, education and employment) are discussed as determinants of inequalities in the policy, efforts to address these underlying factors are delegated to the Scottish Government's Ministerial Task Force on Health Inequalities. The remainder of the policy elucidates how

to reduce smoking prevalence by: (1) preventing smoking initiation in youth; (2) protecting the population from second-hand smoke, especially children; and (3) offering more cessation services to help those who are smoking to quit (Healthier Scotland, 2013). As such, the policy may primarily be categorized as a behavioural-type public health policy (PHP) focusing largely on the reduction of smoking as a behaviour rather than the social conditions that lead to smoking inequities (e.g., poverty). This is important because, while tobacco control policies have been immensely productive in reducing the population prevalence of smoking during the last 30 years, evidence indicates that they may have simultaneously aggravated social inequities in smoking (Corsi et al., 2014; Frohlich & Potvin, 2008; Smith et al., 2009). As such, the use of similar approaches in tobacco control may no longer be a feasible option if the reduction in social inequities in smoking is the goal.

The tobacco control example is not unique. For example, Thomson et al. (2018) have shown how some PHPs that may be efficient in improving overall population health either have no differential health effects or may even increase inequities by disproportionately benefitting more advantaged groups. Lorenc et al. (2013) also caution against such intervention-generated inequities. They find that downstream policies often risk producing differential effects by benefitting higher SES-groups the most. In Canada, for instance, smoking prevalence among women with a university education decreased from 45% in 1950 to 8% in 2011. In contrast, prevalence of smoking in women with less than a high school education only decreased from 40 to 33% (Corsi et al., 2014. See Manuel et al. (2020) for projections to 2041). In concrete terms, the most socio-economically disadvantaged Canadians have benefitted the least from these PHPs (Frohlich & Potvin, 2008).

This critique is not restricted to PHPs such as tobacco regulation. When HiAP sets out to address working and living conditions, based on a social model of health, this does not necessarily entail a redistribution of these factors and thus would not necessarily improve health equity (Baum et al., 2017; Fisher et al., 2017; Graham, 2004). For instance, a study by Chaufan et al. (2014) highlights a blind spot in public health with regard to the drivers of SDH. Chaufan and colleagues argue that environmental changes to the built environment are often suggested as an SDH approach to improve health equity without considering the drivers of inequity such as poverty. Instead, environmental changes are proposed to facilitate behavioural changes (i.e., to make neighbourhoods safer to

walk or bike in and increase access to healthy foods). Such HiAP policies thus fall victim to a similar health drift: they reduce complex issues of health equity to focus primarily on health behaviour. A similar critique can be found in a study by Holt et al. (2017) in which the authors found that environmental changes to the school environment to improve children's level of physical activity and dietary choices (in order to improve their cognitive ability and learning outcomes) may compromise action on the broader SDH.

In sum, the consequence of the dual aim of promoting both population health and health equity is that the intentionality of HiAP is not always clear. In some examples of HiAP, either the policies have sought outcomes other than reductions in social inequities in health, and/or could potentially cause unintentional concentrations of vulnerabilities and increase inequities in health (Baum et al., 2017; Frohlich & Potvin, 2008; van Eyk et al., 2017). For a policy framework to efficiently address social inequities in health, it needs to specifically apply an equity lens, be prepared to confront the issue of inequities as being unfair and mutable and be willing to consider redistributive policy options. This involves an explicit focus on the drivers of inequity rather than merely the health behaviours of the disadvantaged.

3.2 Ambiguous Directionality: The Contribution of Non-health Sectors to Health

A second criticism of HiAP concerns how it is interchangeably considered to place health as the main intersectoral objective (Freiler et al., 2013; Greer & Lillvis, 2014; Wismar et al., 2013) and to entail a "networking strategy" that advances broader societal goals such as sustainability and equity, as well as health (Kickbusch, 2010; Kickbusch & Buckett, 2010; Kranzler et al., 2013; Rudolph et al., 2013). This ambiguity involves a question of how HiAP constructs the role and contribution of non-health sectors. Specifically, should non-health sectors integrate health (equity) objectives as part of their sectoral mission and core services or could the core services of non-health sectors be health promoting in their own right? This distinction is crucially important as it brings attention to the sectoral interests involved and, in doing so, an inherent problem of existing HiAP; which is to ensure legitimacy and to create

motivation among non-health sectors to engage in intersectoral collaboration with the health sector (Degeling, 1995; Holt, Carey, et al., 2018; Khayatzadeh-Mahani et al., 2019).

According to the definition of HiAP, its aim is to make health (equity) concerns a *shared* objective across government sectors. As such, HiAP represents “a continuation of the imperative of health” whereby health is sanctioned as one of the most important policy issues for governments to address (Carey & Crammond, 2014, p. 500). For instance, Wismar and colleagues (2013, p. 2) argue that “we need to better understand how diverse actors such as government officials, private industry and citizens may internalize health as an important objective, as we all have internalized evidence, efficiency, integrity, anti-discrimination and many other values”. Kickbusch et al. (2014, p. 186) describe how HiAP “… implies challenging nearly every societal actor, sector, and institution at all levels of governance to ‘think health’ and to contribute to the circumstances in which people can be healthy”. At least two problems follow from this health imperative.

First, regarding policy content, most SDH are characterized by the fact that they lie outside the health sector. That is, SDH involve the circumstances in which people are born, grow, live, work and age, as it is commonly phrased, and the unequal distribution of these determinants is seen as the driver of health inequity (Graham, 2004; Irwin & Scali, 2010). De Leeuw (2017) lists the most commonly identified sectors as: education, housing and urban planning, transport and mobility, social protection and welfare support systems, as well as energy and sustainable development. As such, the SDH belong to non-health sector domains. This is generally accepted as a fact in the public health community and is the main argument for introducing HiAP. However, it follows that non-health sectors’ main contribution to addressing the unequal distribution of SDH must lie within their sectoral mission and core service provision. That is, targeting the social determinants of health inequity primarily concerns (coordinated) sectoral policy and action by non-health sectors such as providing free, good quality education, proper working conditions, employment opportunities and a minimum income, among others. Thus, the promotion of health itself is not the objective, and the health sector would need to emphasize the importance of resource redistribution in other sectors in order to reach both their own equity goals, as well as the health sector’s objective of reducing social inequity in health (Lynch, 2017).

HiAP is conceptually flawed if the assumption being made is that making health (rather than equity), the objective of non-health sectors will significantly reduce social inequities in health. This reduces the role of non-health sectors in HiAP to be implementers of health policy and, thus, neglects their main sectoral contribution to (health) equity. By contrast, many public policies with (intended or unintended) health effects are not based on a health rationale (de Leeuw, 2017; Storm et al., 2016).

This leads to the second problem of confused directionality: the motivation of non-health sectors to engage in intersectoral collaboration. Health (equity) is often not effective as a "collaboration magnet" to engage non-health sectors (Khayatzadeh-Mahani et al., 2019). At times it may be easy to frame a win–win argument regarding the interrelations and shared interests between sectors, one example being the interrelationships between early child development, education and social inequities in health (Diderichsen et al., 2012; Hahn et al., 2016; Maggi et al., 2010). Another example used by advocates of a HiAP approach is the shared interest across government in reducing ever-expanding health expenditures (Baum et al., 2017; Baum, Ollila, et al., 2013). As described by Cairney et al. in Chapter 11 (2022), policymakers may find it easy to show support to a vague solution to an unclear problem like health inequity before they assign meaning to it (also see Holt, Rod, et al., 2018). It becomes a much greater challenge, however, when government actors need to resolve ambiguity and agree on specific policy designs and instruments, when overall shared aims are to be operationalized and prioritized in the development and implementation of specific policies (Brunsson, 2002; Carey & Crammond, 2014; Holt, Carey, et al., 2018). Then the vague agreement is confronted with the reality of complex policy environments with path dependencies of existing policies, sectoral logics, and various dominant frames, and all potential solutions may be divisive or compete with other government priorities. Non-health sectors may consider the HiAP aim of reducing social inequities in health to be peripheral to, if not incompatible with, their own equity-related objectives. Smith and Weinstock (2019), for instance, argue that intersectoral strategies for health equity by their very nature risk limiting the motivation of non-health sectors to engage in intersectoral collaboration because these strategies take as their starting point the privileging of *health* equity, over equity for other social goods (Smith & Weinstock, 2019). Similarly, de Leeuw (2017) and Holt (2018) find that starting with a *health* argument may sometimes be counterproductive to the aim of engaging

non-health sectors in intersectoral collaboration. Lynch (2017, p. 656) even warns that the framing of social inequity as a problem of health tends to medicalize the problem of inequity, "making it seem less amenable to structural solutions" while implying health imperialism. The problem arises when HiAP supporters collapse complex issues of social disadvantage and inequity into matters of health and advocate health-centric solutions. This type of approach is unlikely to be welcomed by those working in the non-health sectors (Carey & Crammond, 2014). HiAP's tendency to solely promote the integration of health (equity) concerns across government, together with the encouragement for the health sector to take a leadership role (Marmot, 2010), is, therefore, most likely to limit HiAP's ability to create a coordinated approach to addressing the drivers of health inequity (Khayatzadeh-Mahani et al., 2019; Smith, 2013).

Acknowledging this challenge, several scholars have argued for a "win–win" approach (Freiler et al., 2013; Molnar et al., 2016), synergy (Ollila et al., 2013), or for HiAP supporters to use strategic framing or "speak the same language" as collaborating sectors (Hall & Jacobson, 2018; WHO, 2015; Storm et al., 2016; Molnar et al., 2016; Freiler et al., 2013). While this has proven successful in some cases, we caution that a win–win approach risks maintaining the imperative of health if other sectors are treated as instrumental to the aim of improving health (equity) only. In siloed systems (reflecting a bureaucratic logic of specialization), the health sector would find it challenging to legitimately engage non-health sectors in intersectoral policymaking on matters that lie within non-health sectors' own domains, if it is not (at least rhetorically) a matter of health. That is, if policy changes within non-health sectors are sectoral (e.g., better and more equitable education), the health sector would generally not have a legitimate seat at the table. Therefore, HiAP involves a dynamic which tends to maintain the health imperative and, thus, reproduce the challenge of intersectoral engagement, which HiAP is intended to overcome.

To sum up our critiques of the intentionality and directionality of HiAP, we are arguing that the opportunities, as well as the aim of establishing intersectoral engagement and collaboration, are quintessentially different when promoting population health from reducing social inequities in health. For public policy to effectively reduce social inequities in health, it should focus desired change away from any one health issue in isolation, towards the drivers of inequities in the same. Moreover, the

health imperative involved with a HiAP approach may discourage non-health sectors from engaging substantially in intersectoral policymaking beyond peripheral concerns. While, theoretically, the main contribution of non-health sectors to health equity lies within their sectoral domains, the ability of the health sector to facilitate intersectoral policymaking is largely dependent on the legitimacy derived from focusing on health.

Building on Julia Lynch (2017), we suggest that public health would benefit from changing its intersectoral advocacy to ensure equity within the provision of non-health sector's core missions and services, rather than framing it as a health inequity problem (Lynch, 2017). Not only would this hold more potential for targeting the drivers of social inequities (in health), but it would also permit non-health sectors to take leadership of their own equity-related policies and objectives. This would mean less direct policy instruction from the health sector to non-health sectors (which is likely to be met with limited success) and place more emphasis on the connections between sectoral domains. While acknowledging the tremendous task of advocating for social equity in a neo-liberal era, we believe that such an approach holds greater promise in terms of ensuring the creation of public policies that address social equity. As Lynch (2017) argues, health inequity may be an appealing problem frame that makes certain inequality issues more palatable in a neo-liberal policy paradigm than re-distribution policy. However, this framing underscores the inherent complexity: dealing with a wicked problem with multiple interacting, unclear, and distal causes and making the problem seem unamenable to policy intervention and thus making it difficult to act. In contrast, sectoral equity policies have the benefit of being relatively simple to imagine and can be implemented by a much smaller number of actors within one or only a few policy sectors.

4 Towards a Framework Focused on the Reduction of Social Inequities

We propose the capability approach (CA) as a policy framework to guide thinking about how policies from all sectors can increase people's capabilities as an intersectoral goal, rather than health. The capability approach is an explanatory theory of well-being and a normative theory of justice that emerged as a response to the standard limitations to distributional theory (such as utilitarianism and other welfare theories) (Sen, 1992). Over the last 10–15 years, this approach has been proposed as being

potentially important for public health action concerned with the reduction of social inequities in health. The work of the WHO Commission on Social Determinants of Health (CSDH, 2008) and the writings of experts like Jennifer Ruger (2010) have emphasized the importance of considering distributive justice from a capability standpoint in order to effectively address inequities in health (Ruger, 2004). More importantly, for the sake of our argument, the capability approach helps us re-frame the question of "equity of what?" by steering the answer away from equity in health to equity in capabilities.

The core characteristic of the capability approach is its focus on what people are effectively able to do and be; that is, on their capabilities (Robeyns, 2005). Individuals' opportunities to undertake the actions and activities that they want to engage in are what matter. These actions and activities ("doings") together with the "beings", or what Sen calls "functionings", constitute a valuable life. Functionings include, but are not limited to, being healthy, being active as a community member, working, resting, being literate, etc. The distinction between realizable and realized functionings is crucial to the capability approach. "A functioning is an achievement, whereas a capability is the ability to achieve" (Sen, 1987, p. 36). Sen puts much emphasis on the distinction between functionings and capabilities because he believes that well-being should not only include realized functionings but that the ability to choose from a set of alternative functionings is a freedom sui generis (Sen, 1999).

Here Sen puts great emphasis on freedom. Freedom is important to equity issues for Sen for at least two different reasons. First, more freedom gives people more opportunities to pursue their objectives. It helps, for example, in their ability to decide to live as they would like and to promote the ends that they may want to advance (in some public health jargon, this could be equivocated with empowerment). This aspect of freedom is concerned with people's ability to achieve what they value, no matter what the process is through which that achievement comes about (Sen, 2009). Second, we may attach importance to the process of choice itself. We may, for example, want to make sure that people are not being forced to do certain things, take on certain health or social practices, or not able to behave in the way they wish, because of specific constraints.

The focus of the capability approach is not just on what a person ends up doing (or achieving), but also whether he or she chooses freely to make use of that opportunity and what their overall options are. The focus is therefore on the ability of people to choose to live different kinds

of lives within their reach, rather than confining attention only to what may be described as the culmination—or aftermath—of choice. In this sense, freedom is both structured (having collective/shared aspects) and individual. It is this inequity in capabilities, understood as an inequity in choice, that Sen argues is at the core of inequity in society.

Consequently, and in relation to the social determinants of health inequities, HiAP considerations of public policies and programmes based on the CA would include, on the structural side, not only the quality and quantity of available resources, or the realized doings and beings on the agency side, but also, the range of capabilities available to people. As Smith and Seward note, an "individual's capabilities emerge from the combination and interaction of individual-level capacities and the individual's relative position vis-à-vis social structures that provide reasons and resources for particular behaviors" (2009, p. 213). People's ability to use resources will determine the range of options for health practices by shaping their capabilities. In other words, we must consider the "capability sets" from which individuals can draw (Sen, 1992) in order to understand how inequities in health practices come about.

As such, health equity policy discussions must grapple with the larger issues of fairness and justice in social arrangements, including economic allocations, paying appropriate attention to the role of health in human life and freedom. Fundamentally, health equity is not just about the distribution of health (Sen, 1992). Rather, addressing health inequity is about the distribution of a much wider array of resources.

5 Conclusion

To conclude, we suggest that the capability approach may function as a meta-framework for addressing social inequities (in health) when considering HiAP. The CA helps us avoid the health drift of confused intentionality as it demands us to focus on how each sector can promote equity in capabilities within their sectoral domains. As such, it helps us to value the contribution of each sector in reducing social inequities and thus to avoid the problem of ambiguous directionality. While the CA does not prescribe the most efficient governance structures to be used to ensure intersectoral collaboration, it involves understanding sectoral missions in context. Focusing on how each sector can promote capabilities within their sectoral domains may help reduce the complexity of intersectoral policymaking to address the social determinants of health inequity. We

propose that a CA inspired approach to intersectoral policymaking would tend to focus more on the connections between sectoral domains rather than attempting to direct policy action of non-health sectors.

Insisting on an equity lens does represent an enormous and difficult task in a neo-liberal era. However, we argue, the solution to this is not found in an intersectoral "fix" like HiAP. Rather, what is required is the mobilization of multiple stakeholders to establish a social movement and, in turn, public pressure for change.

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