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Commentary: Structure or agency? The importance of both for addressing social inequalities in health

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In their paper entitled 'Rose's population strategy of prevention need not increase social inequalities in health',[1] McLaren *et al.* offer a cogent response to our earlier paper 'The inequality paradox: the population approach and vulnerable populations'.[2] It is a pleasure, and was indeed our goal, to see a lively debate sparked by our initial musings. It is therefore an equal pleasure to respond to their paper as part of a further debate.

McLaren *et al.*'s argument rests in part on the idea that not all population prevention interventions influence social inequalities in health to the same extent. They argue that their influence depends on whether the strategy is what they call structural or agentic; the former targets the conditions in which behaviours occur, the latter, behaviour change among individuals. They conclude that structural interventions are less likely to worsen social inequalities in health than agentic strategies.

While this distinction is interesting it may be somewhat distracting given that social inequalities in health, we have argued in the past, arise due to the interplay of 'both' structure and agency.[3] While McLaren *et al.* rightly cite Anthony Giddens as an important 20th century thinker with respect to the structure/agency debate, they fail to mention that among Giddens' most important contributions to sociology has been his structuration theory.[4] Structuration theory is based on the idea that both agency, defined as the ability to deploy a range of causal powers, and structure, objectified as the rules and resources in society, give rise to people's social practices, which are the activities that make and transform the world we live in (referred to by people in public health as behaviours). Using the heuristic of collective lifestyles,[3,5] it has been argued that an adequate tackling of inequalities in health should address all three aspects of structuration theory (agency, social structure and social practices) rather than structure or agency alone.

Indeed, we thank the authors for bringing us back to some of our earlier reflections with regard to the structure/agency relationship as it plays a crucial role in our new argument regarding vulnerable populations. By using the term vulnerable populations, we sought to move away from risk factor epidemiological thought, which tends to focus largely on behaviour alone, and suggest that some groups are vulnerable with regard to their agency, their position with regard to the social structure and their social practices. It is only by focusing on all three that one would be able to reduce social inequalities in health, as all three are at the base of these inequalities.

However, we agree with McLaren *et al.* that the use of the term vulnerable populations is not without problems, including potential stigmatization. One might consider instead the concept of exclusionary process developed by the Social Exclusion Knowledge Network of the WHO Commission on the Social Determinants of Health.[6] Their critique of the notion of vulnerability is that it emphasizes a state without identifying causes, and that it becomes a characteristic of people and not the result of a process. On the contrary, an exclusionary process originates in the unequal distribution of four types of resources: material, cultural, social and political. It is the unequal distribution of these resources that reproduces health inequalities. This notion of exclusionary processes points to the importance of working upstream in order to address some of the original causes that led to the unequal distribution of these resources.

A final note is warranted regarding our perspective on participation. The authors suggest that participatory strategies may ultimately be agentic if structural conditions are not addressed. It is true that the public health literature tends to be ideological and offers little theoretical breadth with regard to the conditions required in the participatory process. In our view participatory planning is a political process. This process

involves the creation of a social space in which the expression of the various voices usually repressed by the dominant structures in society is sought and facilitated. Participation is a means by which political resources are redistributed. It has the deliberate intention of providing the mechanisms and procedures through which the dominant structures of society can be bypassed and the voices that are seldom listened to, heard. In this sense, participatory planning is in itself a public health intervention that aims to correct political resource imbalance.[7]

We also suggest that participatory processes cannot function without public health practitioners and researchers being reflexive with respect to their own social (and historical/material) location. There is often thought to be a 'right' response to specific practice scenarios, which the 'expert' practitioner will accurately identify, intervene in and resolve.[8,9] Unfortunately, these approaches do not permit for an understanding of the local production of health that is required in order to develop more appropriate strategies for tackling social inequalities in health. As mentioned previously, these strategies would involve reflexivity with regard to the agency, practices and social structural location of practitioners as well as the vulnerable populations one seeks to serve.

One of the bold lessons of 150 years of public health interventions is that there is no one magic bullet. It is only through a variety of complex and complementary strategies that public health problems can be successfully addressed. This is all the more true with regard to social inequalities in health for which public health has begun to identify social processes as intervention targets. Opposing agency and structure ultimately leads to opposing educational strategies to social engineering, neither of which is suitable for addressing social inequalities in health. What we need are interventions that address the processes by which social practices are reproduced, which ultimately depends on the interplay between the social structure and agency.

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