Health in All Policies

Seizing opportunities, implementing policies

Edited by
Kimmo Leppo
Eeva Ollila
Sebastián Peña
Matthias Wismar
Sarah Cook

MINISTRY OF SOCIAL AFFAIRS AND HEALTH
Finland

NATIONAL INSTITUTE FOR HEALTH AND WELFARE

European Observatory on Health Systems and Policies
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Foreword by the Prime Minister of Finland

The aim of my government is to create a caring and successful Finland. The government is committed to act with determination in order to develop and reinforce the basic structures of the welfare society.

The government has three main priorities: a reduction of poverty, inequality and social exclusion; the consolidation of public finances; and enhancement of sustainable economic growth, employment and competitiveness. At a time of austerity, and with an ageing population structure, achievement of these goals is challenging and requires an input from all of us.

Health is a human right and a central element of well-being. Health is also an essential prerequisite for the achievement of our governmental goals.

One of our major concerns is to prolong the working life: to ensure that our youth enters work as soon as possible; that we have a healthy, motivated and capable workforce; and that even those close to retirement age maintain their ability to work. We have made major efforts across sectors to prevent social exclusion of young adults, to maintain the work capacity of those outside the workforce and to facilitate the attainment of employment. Health has an intrinsic link to the ability to work: it plays a core role in addressing poverty and social exclusion, and enhances our potential for economic growth and competitiveness. The other side of the coin must not be ignored: we need to ensure that there are employment opportunities for all and that employment conditions and workplaces promote health and prevent ill-health.

Most public policies have the potential to influence health and health equity, either positively or negatively, and many of our societal goals cannot be achieved without a healthy and well-educated population. Finland has a long tradition of working across administrative sectors, and structures and processes have been developed to accomplish this. Open and transparent policy-making is a foundation for good public policies and adequate resources for implementation and monitoring are essential. An educated and well-informed population forms a basis for functional democracy.

We need a good knowledge base to have evidence-informed policy-making. As regards the Health in All Policies, we need assistance from our Ministry of Social Affairs and Health, as well as the institutes subordinate to it, on how best to incorporate health considerations into policy-making in order to reach our goals as a whole, to enhance well-being, and to improve health and reduce inequity.

My government has made an explicit commitment to promote well-being and health as well as to reduce inequality in all its decision-making. In times of austerity we may select slightly different tools than in good economic times to improve health and health equity. The current government has moved towards health- and environment-based taxation.

We are living in a globalized world which makes us all very dependent on one another. Policy-making takes place at all levels, from global to regional, national to local. Opportunities and challenges, as well as proposed solutions, transcend boundaries. We must aim at anticipating opportunities and threats, so that our efforts – including norms, standards and regulations – are always up to date. We need to share our knowledge and experiences on how best to make good policies that enhance our goals and objectives, and make our societies more just and our populations happier and healthier. This book serves the purpose of sharing experiences around the world. I hope that politicians and policy-makers across sectors in all continents will find it useful and inspirational for their own work.

Jyrki Katainen
Prime Minister of Finland

Foreword by the Director-General of WHO

I warmly welcome this publication and the wide range of experiences it captures from around the world. Its starting point is straightforward: the determinants of health are broad; health is profoundly, often adversely, affected by policies made in non-health sectors. These policies may arise from the decisions of various government ministries or from the workings of the international systems that govern trade, business relations and financial markets.

In a sense, this is nothing new. The sanitary revolution that began in the nineteenth century recognized that the major threats to population health were largely an environmental rather than a medical problem. Vast improvements in health outcomes, especially for the poor, followed the introduction of measures that cleaned up urban filth; improved living and working conditions; introduced sewerage systems; and enhanced the safety of the food and water supplies.

At that time, the principal aim was to prevent epidemic diseases that thrived on dirt and destitution. Today, the enduring challenge of addressing health conditions that have their roots in social, economic and environmental factors takes on added urgency from a more recent epidemic – the relentless rise of chronic noncommunicable diseases in every corner of the world.

The Political Declaration agreed at the 2011 United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases singled out prevention as the cornerstone for the global response to these diseases. I fully agree. Growing evidence shows that economic growth in an interconnected world creates an entry-point for the rise of diseases such as heart disease, stroke, diabetes and cancers (especially cancers linked to tobacco use and obesity). These are the diseases that break the bank. In some countries, care for diabetes alone consumes as much as 15% of the national health-care budget.

The entry point has been opened wide by some powerful, almost universal trends: population ageing, rapid unplanned urbanization and the globalization of unhealthy lifestyles. These trends are difficult to reverse. For example, no country has yet been able to reverse its obesity epidemic.

Prevention requires population-wide interventions that are largely beyond the power of ministries of health to introduce. The health and medical professions can plead for lifestyle changes and tough tobacco legislation, can treat patients and issue the medical bills, but they cannot re-engineer social environments in ways that encourage healthy behaviours. Neither can the health sector, acting alone, open opportunities for people to work (or educate) their way out of poverty.

We know that these kinds of changes are urgently needed, but the question has long been – how? In a highly interdependent and interconnected world, the boundaries of policy spheres have become blurred. A policy that makes perfect sense for one sector can have disastrous consequences for another. In many cases, efforts to prevent noncommunicable disease pit public health objectives against the interests of powerful and highly profitable corporations. How can health arguments be made compelling for much more influential sectors with their own distinct mandates and obligations? What kind of evidence do we need? And will evidence alone be sufficient? Are strong economic arguments the answer, or do they miss the bigger point?

With its emphasis on practical, workable solutions in a range of settings for a range of problems, this publication gives us that long-needed how-to guide. It should do much to convince policy-makers that including health in all policies is a smart – and feasible – policy choice.

Dr Margaret Chan
Director-General, World Health Organization

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List of abbreviations

BOHS	basic occupational health services
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CGWY	Chile Grows With You (Chile Crece Contigo)
COP5	fifth session of the Conference of the Parties to the WHO FCTC
CRC	Convention on the Rights of the Child
CSDH	Commission on Social Determinants of Health
DALY	disability-adjusted life-year
DNHA	Department of Nutrition, HIV and AIDS (Malawi)
DWA	Decent Work Agenda
ECD	early child development
ECD-HiAP	early child development and Health in All Policies
EDI	Early Development Instrument
European Review	European Review of Social Determinants of Health and the Health Divide
FNS	food and nutrition security
GBS	general budget support
GDP	gross domestic product
Global Fund	Global Fund to Fight AIDS, Tuberculosis and Malaria
HiAP	Health in All Policies
HPS	Health-Promoting Schools (China)
IANPHI	International Association of National Public Health Institutes
ICAP	International Center for Alcohol Policies
IFC	International Finance Corporation
IFPRI	International Food Policy Research Institute
IHP+	International Health Partnership
IHR	International Health Regulations
ILO	International Labour Organization
IPCC	Intergovernmental Panel on Climate Change
Kaste Programme	National Development Plan for Social Welfare and Health Care (Finland)
LMIC	low- and middle-income country
MDG	Millennium Development Goal
NCD	noncommunicable disease
NGO	nongovernmental organization
NHA	National Health Assembly (Thailand)
NHS	National Health Service
OECD	Organisation for Economic Co-operation and Development
OHS	occupational health services

OSH	occupational safety and health
PAHO	Pan American Health Organization
SUN	Scaling Up Nutrition
SWAp	Sector-Wide Approach programme
TAPS	tobacco advertising, promotion and sponsorship
ThaiHealth	Thai Health Promotion Foundation
THE PEP	Transport, Health and Environment Pan-European Programme
TRIPS Agreement	Agreement on Trade-Related Aspects of Intellectual Property Rights
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCRC	United Nations Committee on the Rights of the Child
UN DESA	United Nations Department of Economic and Social Affairs
UNDP	United Nations Development Programme
UNECE	United Nations Economic Commission for Europe
UNICEF	United Nations Children's Fund
UNRISD	United Nations Research Institute for Social Development
WHA	World Health Assembly
WHO FCTC	WHO Framework Convention on Tobacco Control
WIND	Work Improvement in Neighbourhood Development
WISE	Work Improvement in Small Enterprises
WISH	Work Improvement for Safe Home (WISH)
WTO	World Trade Organization

Part I

Chapter 1

Introduction to Health in All Policies and the analytical framework of the book

Eeva Ollila, Fran Baum, Sebastián Peña[1]

Key messages

- Health is a core element in people's well-being and happiness. Health is an important enabler and a prerequisite for a person's ability to reach his/her goals and aspirations, and for society to reach many of the societal goals.
- Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies and avoids harmful health impacts, in order to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making.
- Core features of HiAP include a strong foundation on human rights and social justice, and a focus on policy-making. It is often necessary to prioritize efforts; seek synergies to enhance health and other important societal goals; and seek to avoid harmful impacts on health.

1 In addition to the comments of the editorial team, external reviewers and the participants of the workshop held to prepare this book in March 2012, we would especially like to thank Francisco Armada, Gauden Galea and Ilona Kickbusch for their most valuable comments on previous versions of this chapter. Benjamin Meier is thanked for his advice on human rights, and Eemeli Nieminen for her excellent graphic design of the chapter's figures. It goes without saying that final responsibility for the outcome rests solely with the authors of this chapter.

- Application of HiAP involves identifying policy developments across sectors with potential implications for health and health equity; assessing impacts; and advocating and negotiating for changes. Long term vision and sustained efforts are often needed.
- Policy-making is a dynamic process in which windows of opportunity for policy decisions arise from changing economic, social, economic and political realities. This book uses Kingdon's framework on problems, policies, politics and windows of opportunity to analyse the dynamics of policy-making.

1.1 Introduction

People put high value on health; it is core to their well-being and happiness. Good health enables a long, fulfilling and productive life in which a person can enjoy life, study, work and care for others. Healthy children learn more effectively. Healthy adults are able to care for others. Health is also likely to be good for business. Thus, health is an important enabler and prerequisite for attaining not only an individual's goals and aspirations but also society's social and economic goals.

The health sector devotes most of its attention to organizing and financing good quality and accessible health services. While this is crucial, health is not created by health service provision alone but largely also by determinants of health that together affect the health of individuals and communities (1–5).

People's health is affected by the social, physical and economic environments in which they live, as well as individual characteristics and behaviours. Health inequities – defined as avoidable, unfair and unjust differences in health status within and between countries – are also mostly a result of differences in these determinants affecting the circumstances in which people are born, grow, study, live and age, and the systems put in place to deal with illness (1, 6). Public policies can make a major difference for health and health equity by creating healthy environments which also facilitate healthy choices (1).

Thus, public policies dealing with (for example) water and sanitation, education, social services, built and natural environments, agricultural and industrial production, trade, regulation, revenue collection and allocation of public resources have important ramifications for population health and health equity. The infrastructure and regulatory context, professional education systems, revenue collection and resource allocation affect particularly the context in which health systems function. The health sector would need to move outside its sectoral activity to work with others in order to achieve better health and health equity.

Health is not the only societal goal affected by multiple public policies across sectors. The idea of using cohesive policies and actions across the public sector in order to achieve societal goals has been attracting attention within many other fields, including sustainable development, environment and gender. There have been efforts to mainstream these aspects into broader policy-making at various levels of governance. Just as we can learn from those processes, it is hoped that policy-makers across sectors can learn from these efforts around HiAP.

Box 1.1 *Target group of the book*

This book is written for policy-makers worldwide, at the national level within all government sectors influencing health. These include health, employment, housing, economic development, finance, trade, environment and sustainability, social security, education, agriculture and urban planning. It is also aimed at those interested in bridging evidence and policy-making.

This book addresses the ways in which health perspectives can be incorporated into public policies in practice. The main emphasis is on national policy-making and on issues related to health promotion and social determinants of health, although HiAP is a broader concept that encompasses all levels of policy-making and health systems functioning.

Health policy-makers and researchers often marvel that evidence-based solutions to problems are not implemented in practice. One major reason for this is that policy-making involves a range of actors with their own various goals and aims, hence the process is dynamic and often erratic rather than foreseeable and rational. This book seeks to highlight the importance of seizing windows of opportunity for improved policies related to health and equity, backed up by long-term visions, goals and strategies as well as capacities and policy-makers' knowledge.

Several crucial questions are addressed.

- How do health issues get lifted on political agendas?
- How are health problems and intersectoral solutions identified and prioritized?
- What motivates or incentivizes politicians and policy-makers across sectors to take into account the consequences of their policies for health?
- How can windows of opportunity for improving health and health equity be seized?
- What are the key determinants for successful policy-making and implementation of HiAP?

- What is the role of the health sector in policy-making and implementation for HiAP? What capacities are needed within the health sector to advocate, negotiate and implement HiAP?

This chapter introduces readers to the concept of HiAP and key structures and mechanisms for its implementation. This chapter also introduces the non-linear policy-making framework of the book and determinants for implementing policies used as guidance for the chapters in Part II. The final section introduces the chapters that follow, providing a summary of the key ideas covered.

1.2 HiAP

1.2.1 What is HiAP?

This book adopts the definition of HiAP given in Box 1.2.

Box 1.2 *Definition of HiAP* [2]

Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making.

Source: Adapted from WHO Working Definition prepared for the 8th Global Conference on Health Promotion, Helsinki, 10–14 June 2013.

The roots of HiAP can be traced back to the early history of public health (see Chapter 2 for a historical perspective). The term was coined in the late 1990s and explored in depth during the second Finnish EU Presidency in 2006, where it was the main health theme (7, 8).

The goal of HiAP is to improve population health, health equity and the context in which health systems function[2] by amending public policy-making across sectors in order to achieve the most favourable impacts. Public policies that define the role of the public sector and the regulatory space and capacities – as well as education, economic, trade and fiscal policies – are all important in defining the context of health systems functioning (see Chapter 5 on the international aspects of these policies). Decisions outside the direct remit of the health sector – and often outside the national boundaries – also influence the mandate, regulatory scope and resources for health protection, including those

2 The term 'health impacts' is used throughout the rest of the book to describe these three types of impacts.

for occupational, environmental and traffic safety, and for protection from communicable and noncommunicable diseases.

Core features of HiAP include a strong foundation on human rights and social justice, and a focus on policy-making. In practice it is usually also necessary to prioritize efforts and to seek synergies to enhance health and other important societal goals. It is important to seek to ensure that harmful impacts on health, health equity and health systems functioning of policies across sectors are avoided whenever possible.

HiAP finds support in human rights, developed under international law and implemented in national law and policy in many countries. Grounded in the right to health and health-related human rights, this rights-based approach to health has evolved to include government responsibilities for basic health services and determinants of health (9–11). The values of social justice, equity and human dignity are at the heart of HiAP.

Box 1.3 *WHO definition of health*

"Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. ...The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition."

"Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures."

Source: WHO, 2006 (9).

HiAP focuses on policy-making and is therefore concerned with the development and implementation of legislation, norms, standards, major strategies, programmes and decisions on resource collection and allocation, among others. The HiAP approach per se is also applicable for project work. While a well-functioning health sector is beneficial for applying a HiAP approach, HiAP is not involved in formulation or implementation of clinical best practices and other types of clinical work within health service provision.

HiAP does not mean doing everything at all times; it is about doing the best possible within the context of political will and resources. Ideally, HiAP efforts should be carefully prioritized, including selection of the point and timing of action so as to optimize emerging opportunities for health. Box 1.4 shows a set of conducive conditions for HiAP efforts. These include information on the magnitude and importance of the existing health situation, its distribution across population groups and, in particular, knowledge on the underlying determinants of health and causes of inequity. Information on existing (and

forthcoming) proposals for public policies across sectors with potential for major health implications – positive or negative – is equally important. Prioritization of HiAP efforts should go hand in hand with an understanding of the wider policy-making economic, cultural and political contexts that affect the possibilities for success at any given time. Prioritization can also be based on an existing window of opportunity that makes success easy, including expressed interest or invitations for cooperation from other policy-making fields. Finally, prioritization involves identifying policy processes that are unlikely to yield meaningful results and where efforts should not be pursued.

Box 1.4 *Conducive conditions for HiAP*

Resources and skills to:

- analyse impacts of major policies and policy proposals from the health perspective
- communicate and negotiate across sectors
- implement policy decisions
- follow up policies' impacts on determinants of health, and their distribution.

Information on:

- health situation and causes of ill-health, including distributional data on health inequities
- potential health threats
- effective policies/interventions from the health perspective
- policy trends and proposals being developed across sectors
- policy processes and actors beyond the health sector.

Supportive context with:

- political will
- legal backing
- governance structures and processes for intersectoral communication and implementation.

In many resource-constrained settings, implementation of comprehensive public health policies has been strong at the local levels where (for example) local water, sanitation and food policies have been developed together with the health sector (12). For HiAP to be pursued meaningfully in low-resource settings that are heavily reliant on external aid, donors should seek predictable, coherent and sustainable cooperation that is conducive to good development (see Chapters 3 and 13). There is a need for further capacity building of institutions and among civil servants in order to respond to the complex policy issues, particularly in low- and middle-income countries. Capacity building is discussed in more detail in Chapter 14.

Those working in the health sector have an ethical responsibility to bring their public health knowledge and expertise to the policy-making table and to advocate for health and health equity. However, HiAP does not impose health and health equity above all other societal goals and values, but rather advances public health goals by seeking synergies with other important societal goals. Nevertheless, at times there will be conflicting societal aims. In such situations the HiAP approach stresses the importance of ensuring that decision-makers are informed about the potential health impacts, with accountability mechanisms in place to enable decision-makers and the public to follow the health impacts of the decisions.

1.2.2 Applying the HiAP approach

As signatories to the WHO Constitution, governments are responsible for the health of their populations (Box 1.3). Governments are here understood as the structures to which decision-making and implementation (legislature and execution) have been assigned.

However, it should be noted that currently some mandates may have been delegated from national governments to bodies at regional (e.g. regional economic organizations) or even global level, as discussed in more detail in Chapters 5 and 10; while other responsibilities have been shifted to lower levels of administration. HiAP should be applied at all levels so it is crucial to identify the policy-making level at which decisions take place, and how those decision-making processes can be influenced. The EU provides possibly the most visible examples of mandates concerning many important health determinants being delegated from a national to a regional level although, in principle, the mandate for health policy-making remains at national level. In the EU context it is of utmost importance to ensure that health is taken appropriately into consideration when national stands formulated under the auspices of another sector contain issues of importance for health. At the same time, it may be necessary to pursue efforts through the EU-level health administration.

The health sector has an important role in applying the HiAP approach, even in instances where the government honours its responsibility for enabling good health for all. The role of the health sector is to produce evidence on health and health equity, and on health impacts of policies. This may require participation in the identification of policy solutions that are better for health and negotiation on behalf of such solutions. The health sector needs to act as a catalyst for HiAP activity (see Chapter 14) and therefore would benefit from a clear mandate to expand its activities to work across government sectors.

Working with other government sectors requires an understanding of different mandates and goals, and may involve crossing administrative and budgetary barriers between sectors. Different policy actors and professional disciplines have their own languages and approaches to the problems and opportunities in societal development. For this reason HiAP needs to promote an understanding of the language, goals and working methods across government sectors. Awareness of other actors' specific policy-making cycles and other processes is required in order to be able to seize windows of opportunity.

Outside government sectors, the HiAP approach involves seeking participation, collaboration and interaction with several partners, including the public and the media. Public involvement is valuable in itself as it promotes democracy and transparency and increases accountability; also, successful policy implementation depends on public support.

The for-profit private sector has an increasing role in policy-making. While the private sector can be an important partner in realizing health, the niche for private-sector involvement should be carefully considered in order to prevent private for-profit interests taking precedence over public interests. In addition, it is self-evident that appropriate measures to manage conflicts of interest are necessary.

Monitoring of policy trends and proposals being developed across sectors and provision of timely feedback is crucial when applying HiAP. Specific knowledge on the issue in question is often needed. A challenging example of this type of situation is tracking the most important draft trade agreements which are often negotiated by ministries of economy or finance in terms of their economic benefits or in the context of implementing a broader trading framework (13, 14). Assessing their importance for health requires a specific set of capacities and knowledge. This includes the ability to understand the broader context and language in which trade agreements are made; and to analyse the complex agreements from the perspective of health, health equity and health systems (see Chapter 5).

Table 1.1 outlines some generic governance structures, tools and mechanisms that the literature identifies as designed to facilitate collaboration between a variety of parties. Structures for HiAP can be variable: transitory or permanent, narrow or broad. But structures alone are not sufficient to ensure action. In addition, strong leadership and political will are often required for decision-making and sustainable implementation. Intersectoral policy processes – such as consultation procedures, development of governmental strategies and plans, public reporting systems – can provide a substratum for the structures and also be useful in promoting policy dialogue across sectors. Broad policy and

Table 1.1 *Examples of HiAP structures and mechanisms to foster collaboration, coherence and participation*

Mandates	**Description**	**Examples**
Laws and regulations	Legal frameworks designed to foster intersectoral collaboration or promote health-friendly policies.	Article 152 of Treaty of Amsterdam (EU). International agreements such as the Framework Convention on Tobacco Control (WHO FCTC) (see Chapter 10), Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) or the Convention on the Rights of the Child (CRC) (see Chapter 6).
Agreement protocols	Formal or informal agreements of collaboration between governmental or academic institutions, civil society organizations, private enterprises.	Presidential Memorandum – Establishing a Task Force on Childhood Obesity (United States of America).
Accountability frameworks	Legal frameworks incorporating mechanisms to forecast possible impacts on health. Provide legal support to impact assessments (see above).	Health Care Act requires consideration of health impacts in policy-making at municipal level (Finland). South Australia's Strategic Plan provides mandate for HiAP approach.
Political frameworks	Political agreements between political actors establishing common policy goals.	Adoption of HiAP as part of manifesto of a political party prior to election. Bipartisan political support for HiAP.
Structures		
Interministerial committees	Composed of representatives from various governmental sectors. Most often horizontal (i.e. similar administrative levels – national, sub-national, district) but also vertical. Can include nongovernmental organizations (NGOs), private sector and political parties and/or be permanent; time limited; with generic tasks or ad hoc centred around a specific task.	Advisory Board for Public Health (Finland). Intersectoral Commission of Employment (Peru) (15). Intersectoral Commission for the Control of Production and Use of Pesticides, Fertilizers and Toxic Substances (Mexico) (16). Health in All Policies Task Force (California, USA).
Expert committees	Comprising experts from public sector structures, academic institutions, NGOs, think tanks or private sector, often created ad hoc around a specific task. Composition can have a political balance.	Presidential Advisory Council for Pension Reform (Chile) (17).

Table 1.1 *contd*

Support units	Unit within ministry of health or other ministries with a mandate to foster intersectoral collaboration.	Health in All Policies Unit (South Australia, Australia).
Networks	Flexible coordination mechanism composed of institutional partners.	Canterbury Health in All Policies Partnership (Canterbury, New Zealand).
Merged or coordinating ministries	Ministries with a mandate that includes several sectors or responsible for intersectoral coordination.	Ministry of Social Affairs and Health (Finland). Ministry of Health and Family Welfare (India). Department of Social Development (South Africa).
Public health institutes	Public institutes with capacity to monitor public health and its determinants, and to analyse policies and their potential health implications across sectors.	See International Association of National Public Health Institutes (IANPHI) for a comprehensive list (18).
Processes		
Formal consultation procedures and policy dialogues	Practice of formal consultation and intersectoral consultation on major policy proposals.	Parliamentary hearings. Consultations on Convention 169, International Labour Organization (ILO) – indigenous populations.
Preparation of government programmes and strategies	Practice of governments drawing up a plan for their period of office, ensuring that health implications are properly considered in the making of such a plan or strategy paper.	Preparation of important initiatives from the health perspective for governments to consider including in their programmes. National socioeconomic development plans.
Public health policy reporting systems	Intersectorally prepared public health policy reports, and public health surveillance systems on major determinants and risk factors, linking policies, determinants and health outcomes.	National health report in Finland (19). Public health reports in King County, Seattle, USA (Chapter 14).
Tools		
Impact assessments of laws, regulations, policies or financial initiatives	Can be from the health point of view or more integrated; carried out by the health sector or the sector in charge of the initiative; can be legally enforced or not.	Québec and Thailand, see Chapter 12 for a detailed discussion.

Table 1.1 *contd*

Financial strategies		
Grants or financial support mechanisms for partnership activities or joint budgeting	Broad programmes or initiatives with goals and their own budgets to tackle a major issue intersectorally.	National Development Plan for Social Welfare and Health Care (Kaste Programme) in Finland, provides funding for local-level intersectoral work.

Source: adapted from St. Pierre et al., 2009 (20).

accountability frameworks and agreements between collaboration actors can be useful in promoting a clear division of labour and providing guidance and leverage for civil servants. Finally, financial incentives can promote joined-up action.

As HiAP calls for anticipation of health impacts, various forms of impact assessments of policies have been used, such as: health impact assessments; health equity impact assessments; and environmental and social impact assessments with a health component. The last decade has seen a significant growth in the number of health impact assessments conducted and reported, including the formal impact assessments with a substantial health component that are compulsory for projects with potential large environmental impacts (Chapter 12) and those used as a basis in urban planning. These are seen explicitly as a step towards HiAP (21). Many developing countries (e.g. Thailand, Laos, Brazil) have formalized the use of health impact assessment (or environmental impact assessment with a health component) in their decision-making processes and conducted many health impact assessments which have been used to inform decision-making (22).

Health impact assessment should be proportional to the magnitude of the issue – the possible size of the health and health equity impact and the potential population size involved. In addition, it may be necessary to consider processes dealing with irreversible changes; binding long-term commitment or agreements; or major construction and substantial financial decisions. Very often, within ministries' everyday policy-making routines, assessment consists of a rapid appraisal based on the public health knowledge of a particular civil servant or available evidence within the existing public health literature. Noteworthy is the work in Australia to develop a rapid equity focused health impact assessment (described as a health lens) which provides rapid feedback within the time constraints of the policy-makers (23). Generally, equity issues should be included in all forms of impact assessment. A more detailed discussion on impact assessment and accountability mechanisms can be found in Chapter 12.

This book emphasizes the windows of opportunity and the erratic nature of policy-making (see section 1.3) but major changes often take a long time and require sequential efforts. There is often a need for incremental changes over time because sustainable policies can only go as far as the political and public support allows. Chapter 10 demonstrates the long time-frame required to bring about policies that were effective in reducing tobacco usage – happening over decades following the evidence linking tobacco to a range of adverse health outcomes. The long-term nature of policy development is also demonstrated by the case of developing strategies for controlling and preventing NCDs (see Box 1.5) that encompass a wide range of policies, including those concerning nutrition (Chapter 9), tobacco (Chapter 10), alcohol (Chapter 11), and physical environments conducive for physical activity (Chapter 12). Similarly, practical structures and working processes for applying the HiAP approach can be developed over time (24, 25).

Box 1.5 *Global strategies for NCD control and prevention*

Gauden Galea, Pekka Puska

Work on NCD prevention started in many countries in the 1970s (26–28). Initially, this was concerned with intervening in 'lifestyles' in order to sever the causal chain from behavioural risks, through biological changes, to eventual disease onset. This work led to the emergence of concepts of multiple causation. The broad social influences on the determinants of behaviour led to understanding of the need for intersectoral action to make 'healthy choices the easy choices'. More recently increasing attention has been paid to the broader social determinants of NCDs as the driving forces of inequity within and between countries. In the first decade of this millennium, the policy discourse has further evolved to connect the NCD burden with global development concerns: poverty, trade, economic growth and the environment.

Global policy-making for NCDs shows an evolution of the public health approach – three strands of action have developed in parallel over the last few decades. First, the medical approach concerned with the management of disease states and the reduction of risk factors. This is apparent in some of the pioneering work in prevention such as multiple risk factor interventions and, more recently, the 'best buys' for NCD prevention. Second, broadening the scope to address health systems, recognition of the role of non-health sectors and increasing attention to legal and policy interventions (ranging from intersectoral work in North Karelia to the FCTC). Third, wider linkage with the global development agenda and the social and environmental determinants of NCDs that predominated in negotiations at the 2009 United Nations Economic and Social Council (ECOSOC) meetings and the Political Declaration of the UN High-Level Meeting on the Prevention and Control of Non-Communicable Diseases.

Box 1.5 *contd*

A number of policy milestones can be identified. In 2000, the World Health Assembly (WHA) endorsed the Global Strategy for the Prevention and Control of Noncommunicable Diseases (A53/14, WHA53.17). The WHA adopted the FCTC in 2003, and the Global Strategy on Diet, Physical Activity and Health in 2004 (WHA57.17). An action plan for implementation of the global NCD strategy was adopted in 2008 (A61/8, WHA61.14), and the Global Strategy to Reduce Harmful Use of Alcohol in 2011 (29).

The NCD strategy and plan address cardiovascular diseases, cancers, diabetes and chronic respiratory diseases, causes of about 60% of all deaths globally. The intention is to support a coordinated, comprehensive and integrated implementation of strategies and evidence-based interventions, especially at national level. This aims to raise the priority given to NCDs, urging development of national strategies and action plans for effective interventions; fostering monitoring and research; and partnership building. The strategy for disease control is comprehensive but strongly prioritizes integrated prevention such as addressing the major behavioural risk factors common for these diseases – by reducing tobacco use and alcohol consumption, improving diets and increasing physical activity.

In 2011, the First Global Ministerial Conference on Healthy Lifestyles and Noncommunicable Disease Control was organized in Moscow by WHO and the Russian Federation. In addition, the United Nations held a High-Level Meeting of the General Assembly on the Prevention and Control of Noncommunicable Diseases on 19–20 September 2011. These meetings further consolidated the strategies to combat NCDs. In particular, they shifted this topic to the highest level in global policy-making, including the agendas of the various United Nations agencies. By the end of 2012, a global formal consultation had agreed on a comprehensive monitoring framework for NCDs to serve as a basis for driving future responses to the epidemic.

1.3 Analytical framework for the book

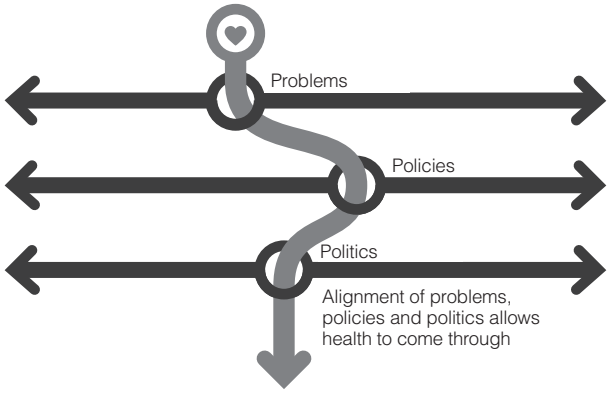
1.3.1 Problems, policies and politics: dynamics of policy-making

This book emphasizes HiAP in the context of the dynamic nature of the policy-making process and the importance of seizing windows of opportunity that may arise from changing economic, social and political realities. Opportunities for action may be seized effectively only when backed up by a long-term vision and health strategies arising from knowledge of public health and the policy context.

In order to understand the policy processes behind successful implementation of a HiAP approach, this book draws inspiration from Kingdon's (2011) multistream policy framework to complement the common emphasis on

what the problem is and what should be done (policies) with analyses on what has happened in reality and why (politics) (30, 31). A well-known American political scientist, Kingdon proposes the existence of three non-linear streams in policy-making – problems, policies and politics – which interplay to open windows of opportunity for policy decisions (Fig. 1.1).

Fig. 1.1 *Illustration of Kingdon's non-linear framework for policy-making*



Firstly, an issue needs to be recognized as a "**problem**" by politicians, policy-makers and the overall community before it can be raised in the policy-making agenda. This is most easily achieved on an ad hoc basis through focusing on events such as disasters, accidents or crises and the linked media attention. Fortunately, more deliberate or planned avenues are also possible. For instance, research results showing key information on the magnitude of the problem; worrying changes in the situation; failures to meet previous goals; or rising costs, can be very effective in raising awareness. International efforts also provide opportunities for the health sector to raise HiAP on national agendas – for example, the work of the WHO Commission on Social Determinants of Health (CSDH) (Chapter 4) or the 2011 United Nations High-Level Meeting on the Prevention and Control of Noncommunicable Diseases. It is important to bear in mind that opportunities may also arise from policy development within other sectors and it is essential that health policy-makers identify such gateways for action. Ideally, policy processes across sectors would be screened for major impacts on health, health equity or health systems and those of high priority would be analysed further. The rising cost of health-care provision is proving to be an important factor for motivating governments to adopt a HiAP approach as one response to the perceived crisis (32).

Secondly, proposals for solutions to the problems are required, in other words – "**policies**". Often developed by policy communities (including public

institutions, universities, think-tanks and/or private bodies) these provide alternative solutions for the problems. To achieve success, these policies should be technically sound, culturally and ethically acceptable and financially reasonable (30). Such solutions are accepted more readily if they do not conflict with other interests, and therefore it is often worth studying other interests and pursuing such solutions.

Thirdly, a policy change is possible only if the "**politics**" environment is right. Policy-makers need to be able to recognize appropriate moments in politics when a policy change would be most likely to be adopted. Suitable opportunities often rise in election campaigns; during the establishment of a new government; or during a change in the power balance in parliament, such as the rise of a new coalition. A financial crisis can also provide an opportunity if, for example, raising taxes on harmful products is viewed as an appropriate option. There is also a need to identify relevant actors and policy-making processes. The political process involves negotiations between all the parties involved and the more conflicting interests there are, the more difficult the process to find a common solution (30, 31). The analysis of the political stream in the Part II chapters identifies the main actors, power relations, conflicts of interests and political will.

Kingdon discusses the importance of "policy entrepreneurs." The policy examples provided in this book highlight their role in putting health on the policy agenda and in the follow-up to the development and implementation of policies. Major actors raising health issues on policy-making agendas include public health researchers and policy-makers, civil society organizations and the community itself. Civil society and (especially) international NGOs have often played important roles in identifying potential problems for health in international policy discussions and policy proposals as well as ensuring they are addressed during discussions of policy solutions. Private industries also can be powerful actors in either raising issues on the agenda or ensuring that they are not raised (see Chapters 10 and 11). Finding appropriate solutions requires both formal expertise (through research and development in either public or private sectors) and lay knowledge and experience (33). Chapter 3 highlights the importance of community participation in shaping the development agenda; Chapter 8 the importance of developing policies for good mental health. Responsibility for the feasibility assessment of solutions for a given situation lies within the expert community of the public sector.

1.3.2 Importance of windows of opportunity

Windows of opportunity are understood here as a short period of time in which, simultaneously, a problem is recognized, a solution is available and the political climate is positive for change. These are critical opportunities for policy entrepreneurs to tackle important policy problems.

A problem may be identified for long periods before any actions are taken. An alternative may have gained wide consensus among experts before an opportunity arises. For instance, the policy community had long identified Ecuador as a country with high binge-drinking rates and one of the highest unrecorded per capita consumptions of alcohol in Latin America. But nothing was done until 50 people died and 14 were left blind due to bootleg liquor in June 2011. In response, the authorities introduced a three-day ban on alcohol sales and bought back any contaminated alcohol still in circulation (34). Since then, Ecuador has seen great progress: an intersectoral alcohol policy was launched in April 2012; a tax reform increased excise tax for imported alcohol significantly; and several local districts have banned alcohol sales and consumption on the streets during public festivities (35–38).

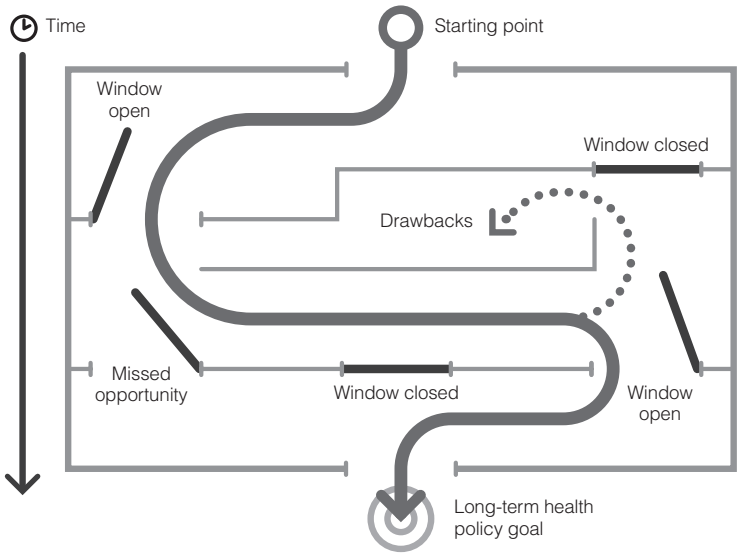
As discussed before, windows of opportunity can also emerge when evidence from policy problems or from monitoring policy implementation finds a favourable political, social and economic context, and when there is a solution (policy) that can be adopted. Policy-makers can also try to keep a policy window open by, for instance, moving from awareness to proposal of policy alternatives.

In the context of policy-making, a long-term vision is essential to guide the policy process over the course of a longer time span and allow policy-makers effectively to seize windows of opportunity. Progress is made by taking opportunities as they arise but, at a given political time, some windows might be closed or missed because of lack of awareness of policy processes in other sectors. There can also be drawbacks that worsen the situation (Fig. 1.2).

1.3.3 Implementation of policies

If policies are to have an impact, they need to be implemented. This is always a challenge but particularly so when a policy involves several sectors. Usually, the implementation process has been defined as a step that follows a policy decision. However, this should be carefully considered even earlier so that the decision can be informed by the implementation possibilities. This includes having a clear idea of the division of labour, resources available and mechanisms to follow implementation and its effects. It is also important that those affected by the decisions (including the lower levels of administration, for example) are informed and consulted before major decisions are taken, otherwise there will

Fig. 1.2 *How windows of opportunity shape long-term policy-making*



not be sufficient involvement to ensure successful implementation. This book explores the main determinants and barriers for successful implementation, including the role of political will, legal frameworks, structures and sustainability.

Accountability for the health impacts of public policy decisions and their implementation can be enhanced by approaches such as: greater transparency in the decision-making process; facilitating public discussion on important policy decisions; improving awareness of potential health impacts before decisions are taken; and enhancing civil society organizations' role as watchdogs. Systems for monitoring and evaluating the impacts of implemented policies should be in place.

1.4 Guided tour of the rest of this book

This book has been carefully crafted to provide policy-makers with practical policy experiences relevant to their own settings and to countries at different stages of development. The book is structured in three complementary parts. Part I sets the scene for HiAP, starting with a historical perspective on efforts towards comprehensive health policy-making, including the Alma-Ata Declaration and various global health promotion conferences (Chapter 2). Chapter 3 discusses the relationship between health and development, and HiAP's role in resource-constrained settings. Appointed by WHO, the Commission on Social Determinants of Health (CSDH) analysed the most important factors affecting people's health and health equity – particularly the conditions in which people

are born, grow, play and work – and recommended actions to be taken. Most of these determinants and actions to tackle health inequities lie outside the reach of the health sector. Chapter 4 reviews the recommendations and outlines developments at global and national levels following the CSDH's final report. In an era of globalization, many decisions that affect the options for national health policy-making are made in forums not only outside the health sector, but also outside national borders – at international levels. Chapter 5 discusses globalization and national policy space for health with special emphases on trade and financial policies.

Part II advances the state of the art of HiAP by providing eight policy examples. These aim to shed light on different policy needs, ranging from the focus on health outcomes (Chapters 6 and 8 on childhood development and mental health, respectively) and risk factors (Chapters 10 and 11 on tobacco and alcohol consumption, respectively) to a variety of policy fields. The analyses of cross-sectoral issues, such as employment, work and health (Chapter 7) and agriculture, food and nutrition (Chapter 9) provide some ideas on the challenges of intersectoral collaboration and possible solutions. Major risk factors for NCDs are examined in Chapters 9–12, rather than in a single chapter. Chapter 12 presents a detailed exploration of impact assessment and accountability issues in the context of environment and health. The question of whether HiAP can be used to make development assistance for health more effective is analysed in Chapter 13.

Part III brings together the preceding parts for a re-examination of the health-sector's role. The main lessons for the health sector shown in Parts I and II are highlighted in Chapter 14, identifying the capacities and resources needed to take up the sector's new role in HiAP. Chapter 15 brings the book to a conclusion by outlining and addressing the crucial questions and providing lessons for policy-makers.

Many important challenges that could benefit from a HiAP approach could not be included in this book, including ageing, migration, communicable diseases; important determinants such as housing and transport; and lines of inequality such as race or religion. Yet, despite this constraint, it is hoped that the book offers sufficient different types of issues to allow deeper scrutiny; provide more generic lessons for applying HiAP; and (perhaps) for mainstreaming other major societal goals.

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Chapter 2
History of HiAP

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Key messages

- The understanding that health is largely created by factors outside health-care services has developed throughout history from at least the nineteenth century, expressed in many different contexts including: the WHO Constitution; Alma-Ata Declaration; Ottawa Charter; and, more recently, the CSDH final report; the Political Declaration of the United Nations General Assembly High-Level Meeting on the Prevention and Control of Non-communicable Diseases; and the Rio Political Declaration on the Social Determinants of Health.
- History shows that action on the social, economic and environmental determinants of health involves multiple sectors and includes political and social struggles.
- Activities towards improving health impacts of policies across sectors have only recently been labelled as HiAP but many historical actions have shared similar aims and strategies, including intersectoral action and healthy public policy which emerged from the health promotion movement in the 1980s.
- Recent history suggests that HiAP is implemented differently in different contexts, reflecting local social and political cultures and administrative structures.

2.1 Introduction

The idea that a very significant portion of the creation of health lies outside the health-care sector has evolved in many different times and contexts. Central to this idea is the concept of social determinants of health (incorporating social, economic and environmental determinants) which forms the rationale for HiAP.

This chapter provides a brief history of societal recognition of the importance of these determinants and the related policy responses. It also examines the social and political contexts within which these responses occurred (see overview in Table 2.1).

Table 2.1 *History of the idea of HiAP*

	Development of HiAP idea	**Social & economic context**
19th century	Progressive social reformers noting health equity impacts of industrialization: e.g. Villerme (France), Engels (UK), Virchow (Silesia) UK Public health and sanitary reform movement; Chadwick and Health of Towns Association Actions of social and political movements from civil society and trade unions brought about significant improvements in nutrition and living conditions (housing and urban planning) resulting in longer life expectancy by end of century	Industrial revolution – massive social dislocation Laissez Faire government in early/ mid 19th century In Europe, social and political movement for improved working and living conditions Growth of trade unions
20th century	1948 Foundation of WHO Latin American social medicine movement 1950s/60s; Basic need approach & example of low income high health countries 1978 WHO Alma-Ata Declaration on Primary Health Care 1986 WHO Ottawa Charter for Health Promotion; Healthy Cities project (1995 WHO Twenty steps for developing a Healthy Cities project) 1988 Adelaide Recommendations on Healthy Public Policy and subsequent WHO health promotion conferences	World War 1 – greater focus on health of populations National building, eugenics movement Great Depression New Deal in the United States of America Formation of welfare states which provide education, health, housing and social protection Growth of neoliberalism reducing role of state including 1980s/1990s structural adjustment programmes; Washington Consensus (1989); foundation of World Trade Organization (WTO); Selective primary health care World Bank *Investing in Health* report
21st century	Millennium Development Goals (MDGs) 2000 People's Charter for Health EU Health in All Policies 2008 CSDH 2011 UN High-Level Meeting on the Prevention and Control of Non-communicable Diseases Rio Political Declaration on Social Determinants of Health 2013 WHO 8th Global Conference on Health Promotion	Global financial crisis, bank bailouts and austerity politics Growing awareness of ecological crisis

2.2 Nineteenth-century origins of HiAP in Europe

In the nineteenth century, the birth of the modern public health movement in Europe saw widespread acknowledgement that living and working conditions had a massive impact on health and that health was created through the conditions of everyday life. Led by the United Kingdom, the industrial revolution in Europe was creating large cities with rapidly growing populations. Infectious diseases (including cholera, typhus) were spreading in the unsanitary conditions the working classes had to endure. In England, Chadwick's *Report on the Sanitary Conditions of the Labouring Population of Great Britain* resulted in the 1848 Public Health Act, granting local authorities the power to remedy unsanitary conditions and to require adequate drainage and sanitation in towns (1). Reformers such as Villerme in France, Engels in England and Virchow in Silesia recognized that disease affected the poor more than the rich and that social conditions were vital in this relationship. All three documented health inequities and advocated action in a range of sectors to improve the lot of the poor. Engels reported on the living conditions of the working classes in Manchester in 1844 (2). Convinced that the ability to resist disease was a reflection of an individual's class and social position, he surmised that changes to working and living conditions were likely to be influential in preventing disease. In 1848, Rudolf Virchow drew similar conclusions when reporting on a typhus epidemic in the Prussian region of Upper Silesia: noting that the underlying social and working conditions were important causes (3). Virchow eventually became a prominent leader in the 1848 German Revolution and a member of the Prussian Parliament.

Building on Virchow's work, Neumann prepared a draft public health law in 1848 (4). This stated that public health must care for society as a whole by considering the general physical and social conditions that may adversely affect health (such as sanitation, industry, food and housing), and must protect the individual by considering those conditions that prevent a person caring for his/her own health. Neumann's recommendations called for improved nutrition, more employment, better housing and free public education. Researching the links between wealth, poverty and health in Paris, Villerme found a strong relationship between relative rates of poverty in the city's 12 arrondissements and their rates of mortality (5). Thus, Engels, Virchow, Neumann and Villerme clearly showed that patterns of disease reflected broader social inequities and that action from government and city authorities was necessary to improve health and reduce the incidence of infectious disease.

It became evident that rising living standards, rather than improvements in medical technology, were responsible for the decline in mortality from the mid-nineteenth to the mid-twentieth century (6). Also, that economic growth

alone did not guarantee improved health: government interventions in terms of improved sanitation, urban planning and education translated the fruits of economic growth into improved health. These needed to be fought for (7) and civil society played a vital role in advocating for these health-improving investments. For instance, the active Health of Towns Association formed in England in 1844 held public meetings to demand that city and central governments took action to improve the living conditions of the emerging industrial working class in order to improve their health (8). The emerging trade unions were also important in the struggle for working class health. The latter part of the nineteenth century was characterized by central and municipal government reforms leading to improved living conditions through: better quality housing offering water and sanitation; urban planning; improved food supply; and the extension of education and literacy. Lewis (9) also notes that the democratization of the mid to late nineteenth century not only extended the franchise but also produced an electorate in favour of public spending to control the excesses of the free market.

The European nineteenth century public health movements highlight the essentially political nature of public health and how civil and political actions combine to lead to healthy public policy (9). None of the gains made was a result of action from within government alone, each involved active pressure groups lobbying and advocating for healthier living conditions and forcing governments to take action.

2.3 First four decades of the twentieth century

Across industrialized countries, the period from 1900 until the end of the 1930s was characterized by a concern with strengthening the nation by improving the health and fitness of white citizens in particular and the quality and quantity of the population. Extension of state intervention in education, social services, regulation of labour and industry had positive impacts on health (10, 11). In the United States of America, President Franklin D. Roosevelt conceived his New Deal as a response to the Great Depression of the 1930s but this was also good for the health of the population as it gave rise to employment projects and provided some protection from the excesses of the depression. Other social reforms of this period had positive impacts on health: including a search for the form of ideal cities and the extension of health education (especially for mothers and children). In this period, being healthy came to be seen as the duty of a good citizen in many industrialized countries. There was also consolidation of the idea that governments bore some responsibility for the health of citizens and that living environments played a key role in this.

2.4 Post Second World War

In most Organisation for Economic Co-operation and Development (OECD) countries the period from the mid-1940s until the 1970s witnessed the establishment of welfare states and saw many of the vital social determinants of health being extended to whole populations. This was a time of high employment and growing consensus on the importance of universal education, welfare and health services. As in the nineteenth century, this evolution resulted from political and social movements that fought for the establishment of welfare states. These appear to contribute to the reduction of health inequity: countries with the most progressive welfare states having the lowest rates of inequity (12,13).

The optimism of the post-war period led to the establishment of United Nations' systems, including the WHO. Central to the United Nations was the 1948 adoption of the Universal Declaration of Human Rights setting out an aspirational set of rights for all people. Formulated in the same year, the WHO Constitution states explicitly the broader view on health and reflects the need to tackle health across sectors (Box 2.1).

Box 2.1 *Extracts from the WHO Constitution*

Article 2

In order to achieve its objective, the functions of the Organization shall be:

(*h*) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries;

(*i*) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene;

(*k*) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective.

Source: WHO, 1948 (14).

Many developing countries joined the path to independence from the 1960s. This increased their importance in global policy-making and, in the 1970s, they called for a new international economic order. At this time, the ILO developed the basic needs strategy, which included the fulfilment of material (e.g. food and nutrition, drinking water, shelter, clothing, health, education) and non-material needs related to people's involvement in decisions affecting their daily lives and leading to self-reliance. These received widespread support from within the United Nations family, as well as among donors and developing countries.

With its roots in the nineteenth century, the social medicine movement in Latin America developed with a strong emphasis on the need to attend to the social basis of health (15). Salvador Allende (Minister of Health 1939; President of Chile 1970–1973) was a key proponent, noting that: "...all those medical measures taken will only provide benefits if they are accompanied by economic and financial resolutions that permit a rise in the standard of living of our citizens" (16).

Several developing countries – such as Cuba, Sri Lanka, Costa Rica and the Indian State of Kerala – implemented innovative approaches that rested on providing not only primary health-care services but also services for healthy living conditions (e.g. education, housing, water and sanitation) (17–19). Analysis of these countries suggests that they have achieved their relatively high health by following development strategies that prioritized ensuring that the basic needs of all people were met. Werner and Sanders note that these countries "focussed on equitable forms of service and/or production aimed at involving as a large a sector of the population as possible." Also that "in these countries a cooperative, community approach to resolving problems and meeting mutual needs was encouraged. A spirit of sharing and working together for the common good was an underlying motif" (20). Education was widespread and high levels of literacy resulted; agriculture was based on small-scale farming methods used to grow food for local consumption rather than export; and primary health care formed the basis of the health systems.

The experience of the low-wealth/high-health countries – as well as the ideas of the basic needs and the new international economic order discussed under the auspices of the United Nations – formed part of the basis for WHO's adoption of the concept of primary health care (21). This laid out an approach to health deeply rooted in a social understanding of health and advocated the importance of intersectoral action for improving population health. Given the need for involvement and coordination of all sectors, the Alma-Ata Declaration on Primary Health Care called for governments to formulate national policies, strategies and plans of action to launch and sustain comprehensive primary health care. To that end the WHO worked towards "intersectoral action for health" in collaboration with major United Nations agencies (22) and through strategies developed in individual regional offices.

The WHO Health for All strategy has been more of an inspirational vision for primary health care than a precise blueprint for action. The difficulties preventing the strategy being turned into concrete action include: a lack of political and economic support; the medical profession's conservatism; and a lack of guidance on implementation. Despite the focus on intersectoral action, implementation of the comprehensive primary health care concept remained

weak. It was weakened further by the concept of selective primary health care (25, 26) which called for a narrower set of actions focused on specific diseases and undermined Alma-Ata's more comprehensive vision focused on social determinants (27).

Major development aid donors continued to support this renewed emphasis on selective health-care interventions. This was coupled with structural adjustment programmes which further damaged developing countries' capacity to provide universal health services. In turn, the weakened position of the health sector prevented efforts to foster intersectoral collaboration (23–25, 28). This happened in a global context of shifts towards neoliberal policies which promoted privatization; increased emphasis on targeted approaches with clearer time-limited action; and results-based funding where inputs and output can be connected and money flows followed, an approach not easily compatible with integrated intersectoral actions and policies (24).

2.5 Health promotion movement

The formal health promotion movement began in the 1970s, with a focus on lifestyles and behavioural change drawing on psychological theories to reduce disease risk factors. Recognition that these approaches met with very limited success in the absence of more structural changes to the conditions shaping people's health in their everyday lives led to increasing interest in the role that all sectors play in creating or detracting from health.

The other strand of thinking that has contributed to a focus on HiAP has been the idea of the salutogenic model (29, 30). The idea that health promotion is a very different endeavour to disease prevention was at the forefront for establishing the series of WHO health promotion conferences that started in Ottawa in 1986 (31). The resulting Ottawa Charter states that health happens "where [people] learn, work, play and love", identifying five action areas which play a significant role in generating health including, of course, the importance of healthy public policy. This approach "puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of health consequences of their decisions and to accept their responsibilities for health" (31). Each successive health promotion conference has broadened and deepened the ideas and thinking behind health promotion; Table 2.2 lists these conferences and their key relevance to the idea of HiAP. There has also been a progressively greater focus on the concerns of low- and middle-income countries and recognition that promoting health has to be seen as a global endeavour as well as a national one.

In the 1980s, the health promotion movement also gave rise to the related concepts of intersectoral action for health and healthy public policies to describe cohesive action in public policy-making for improving health and health equity. Intersectoral action for health stresses working together with other sectors; healthy public policies stresses the need to improve the health impacts of public policies. Like HiAP, their major aim concerns the pursuit of improved health and health equity by going beyond health sector activities. The context of policy-making has evolved since the 1980s, consequently HiAP places more stress on the multilevel policy-making reality of today's globalized world. This requires analysis of the precise actors and level of governance at which decisions are taken, making explicit reference to the right to health as well as accountability for health impacts. The scope of HiAP also extends to the context of health system provision to look at decisions which, for example, affect the regulatory context, revenue collection, resource allocations, access to services and education of professionals.

Used more often in the most recent international declarations, the terms 'whole of government' and 'whole of society' emphasize the achievement of government or broader societal goals and, in the context of health, stress the health sector's role in achieving these. The whole-of-government approach refers to governmental structures. However, the whole-of-society approach makes no distinction between the different roles of policy-making actors and includes, for example, the profit-making sector together with democratically elected bodies and popular movements. Again, these terms have some overlap with HiAP but are more concerned with governmental or broader goals to which health makes some contribution; HiAP is most typically facilitated from the health sector which then involves other sectors.

Table 2.2 *WHO international conferences and key documents on primary health care, health promotion and social determinants of health: relevance to HiAP*

Conference	Relevance to HiAP
1978 International Conference on PHC (Alma-Ata)	Produced *Alma-Ata Declaration on Primary Health Care* promoting a social view of health and advocating importance of intersectoral action for achieving health for all.
1986 First International Conference on HP (Ottawa)	Produced *Ottawa Charter for Health Promotion* – among the five strategies for health promotion included "promoting healthy public policy" and "creating supportive environments for health."
1988 Second International Conference on HP (Adelaide)	Produced *Adelaide Recommendations on Healthy Public Policy* defined as "an explicit concern for health and equity in all areas of policy and by an accountability for health impact".
1991 Third International Conference on HP (Sundsvall)	Produced *Sundsvall Statement on Supportive Environments for Health* which "recognized that everyone has a role in creating supportive environments for health" and stressed the importance of community empowerment.

Table 2.2 *contd*

1997 Fourth International Conference on HP (Jakarta)	Produced *Jakarta Declaration on Leading Health Promotion into the 21st Century.* More than previous declarations focused on low- and middle-income countries and advocated that public and private sectors should promote health and that health development required a multisectoral approach; and emphasized the importance of health promotion partnerships.
2000 Fifth Global Conference on HP (Mexico City)	Produced *Mexico Ministerial Statement for the Promotion of Health: From Ideas to Action.* Identified key action "to position the promotion of health as a fundamental priority in local regional, national and international policies and programs" and also "to advocate that UN agencies be accountable for the health impact of their development agenda".
2005 Sixth Global Conference on HP (Bangkok)	Produced *Bangkok Charter for Health Promotion in a Globalized World.* Reinforced the basic strategies of the *Ottawa Charter*, extended their relevance for a globalized world and made HP central to the global development agenda, a core responsibility of all governments and a requirement for good corporate practice. Called for global governance to address harmful impact of "trade, products, services and marketing strategies".
2008 Final Report of CSDH	Provided extensive evidence on the impact of the social determinants of health and so the health impacts of activities in multiple sectors. Recommended the use of health equity impact assessments and endorsed the HiAP approach.
2009 Seventh Global Conference on HP (Nairobi)	Produced *Nairobi Call to Action for Closing the Implementation Gap in Health Promotion.* Calls for governments to make HP integral to the policy and developmental agenda. This includes implementing the recommendation of the CSDH.
2010: Health in All Policies International Meeting (Adelaide)	Produced *Adelaide Statement on Health in All Policies* which "emphasizes that government objectives are best achieved when all sectors include health and well-being as a key component of policy development."
2011: World Conference on SDH (Rio de Janeiro)	Produced *Rio Political Declaration on Social Determinants of Health* which states: "Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies".

PHC: primary health care; HP: health promotion; SDH: social determinants of health.

Implementation of the idea of intersectoral action met with most success at the local level in the 1980s and 1990s. Developed to implement the strategies of the Ottawa Charter, the WHO Healthy Cities project was able to work with city governments to implement a range of actions across municipalities in order to promote health (32). These initiatives have been implemented in hundreds of cities around the world, engaging in processes of city development and urban planning to make these processes more inclusive of health concerns (32).

2.6 Twenty-first century

In the early twenty-first century WHO established two commissions tasked with considering the broader determinants of health. The Commission on Macroeconomics and Health (the Sachs Report) relied heavily on the view that health is important because it is an essential support for economic development. So, while it certainly recognized the importance of health to other sectors, it said less about the need for action in those sectors. The CSDH was grounded in a human rights view of health that saw the achievement of equitable health as a moral imperative. It was established to examine the evidence on the importance of social determinants in health equity and to recommend actions to reduce health inequities (see Chapter 4). The CSDH recommendations include a call for "health equity in all policies, systems and programmes", noting that "coherent action across government at all levels is essential for improvements in health equity" (33).

In 2000 the United Nations adopted the *Millennium Declaration* which provided a value base for international relations, setting developmental objectives for the new millennium that emphasized peace, poverty eradication, environmental protection, promotion of human rights, democracy and good governance. The United Nations operationalized the declaration into eight Millennium Development Goals (MDGs) – three of which are specific health outcomes; four target essential health determinants.

The United Nations High-Level Meeting on the Prevention and Control of Non-Communicable Diseases was convened in September 2011 to discuss care, cure and protection (see also Case study 1.1). The resulting political declaration issued a call for WHO, other relevant United Nations agencies and key international organizations to work together in a coordinated manner to support national efforts to prevent and control NCDs and mitigate their impacts. Shortly afterwards, in October 2011, WHO convened a follow-up meeting to the CSDH in Rio de Janeiro. This meeting resulted in the Rio Political Declaration on Social Determinants of Health, addressing the importance of HiAP as shown in Box 2.2 and also Chapter 4.

In recent years, health has become more prominent on global and national agendas. This is partly because of increasing understanding that health problems such as communicable diseases can be regarded as security issues; partly because health services and technologies are expected to provide potentially growing markets in the context of declining traditional industries in industrialized countries. Globalization has increased the mobility of not only things and capital but also people, enabling communicable diseases to spread rapidly across national borders.

Box 2.2 *Extracts from the Rio Political Declaration on Social Determinants of Health*

Article 2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.

Article 7. Good health requires a universal, comprehensive, equitable, effective, responsive and accessible quality health system. But it is also dependent on the involvement of and dialogue with other sectors and actors, as their performance has significant health impacts. Collaboration in coordinated and intersectoral policy actions has proven to be effective. Health in All Policies, together with intersectoral cooperation and action, is one promising approach to enhance accountability in other sectors for health, as well as the promotion of health equity and more inclusive and productive societies. As collective goals, good health and well-being for all should be given high priority at local, national, regional and international levels.

The Declaration included the following pledges to:

- Work across different sectors and levels of government, including through, as appropriate, national development strategies, taking into account their contribution to health and health equity and recognizing the leading role of health ministries for advocacy in this regard.
- Adopt coherent policy approaches that are based on the right to the enjoyment of the highest attainable standard of health, taking into account the right to development as referred to, inter alia, by the 1993 Vienna Declaration and Programme of Action, that will strengthen the focus on social determinants of health, towards achieving the Millennium Development Goals.
- Support social protection floors as defined by countries to address their specific needs and the ongoing work on social protection within the United Nations system, including the work of the International Labour Organization.

Source: WHO, 2011 (34).

Governments around the world are facing challenges in providing affordable and equitable access to health services, given the changes in demand (due to epidemiological and demographic transitions, as well as raised expectations); increasingly costly medical technologies and pharmaceuticals; and pressures to privatize health service provision. Health expenditure hits vulnerable populations harder, pushing them into poverty and reinforcing social exclusion. At the same time, health has also become entwined in discussions about trade, intellectual property rights (of pharmaceuticals) and trade in (health) services, reducing countries' policy space to keep populations healthy (see Chapter 5). Also, a

growing global movement – for instance, the People's Health Movement (35) – arguing for health as a human right sees access to both health-care services and the social determinants of health as necessary for achieving health and health equity. These trends have reinforced the need for intersectoral collaboration and explain the emergence of HiAP as a promising policy approach in 2006.

In the EU context, HiAP has its foundation in the 1992 Maastricht Treaty which stated that "health protection requirements should form a constituent part of the Community's other policies" (36). Health provisions in the Maastricht Treaty were further strengthened in the Amsterdam Treaty in response to the mad cow disease crisis (37). Article 152 of the 1997 Amsterdam Treaty on the EU states that "a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities" (38). During the first Finnish presidency of the EU in 1999, a council resolution was adopted to ensure health protection in all policies and activities of the EU. However, HiAP was launched more specifically in the EU during the second Finnish EU Presidency in 2006 (39, 40). In force since 2009, the Lisbon Treaty incorporates HiAP in Article 168 using similar wording to Article 152 in the Amsterdam Treaty (41).

Yet, although HiAP was made one of the key principles in EU health strategy (42), in practice it has not reached the expected significance in EU policies (43). For example, the core strategy document *Europe 2020* includes no role for health beyond the potential for innovation, investment, employment and trade related to the health sector, including health technologies (44).

Nonetheless, HiAP has sparked some interest in south-east Europe. For example, in Banja Luka 10 south-eastern European ministers of health signed a pledge that included a commitment for their governments to work towards HiAP in their countries (45, 46). Beyond Europe, the Government of South Australia is implementing HiAP and, together with WHO, organized the Adelaide 2010 International Meeting on Health in All Policies which has been crucial in expanding interest in HiAP outside Europe (47).

A realist-informed review of HiAP initiatives around the world (52) in 2010 found examples of HiAP approaches in 16 countries or subnational areas – Brazil, Cuba, England, Finland, Iran, Malaysia, New Zealand, Northern Ireland, Norway, Québec, Scotland, South Australia, Sri Lanka, Sweden, Thailand and Wales. The review also showed that the approach to HiAP differed significantly across these jurisdictions. Case study 2.1 shows some examples of ongoing initiatives to implement HiAP at national and subnational level.

Case study 2.1 *Selected cases of implementation of HiAP at national and subnational levels*

In **Finland** the HiAP approach has developed over several decades. HiAP in Finland has evolved from a focus on concerted actions on high-priority issues towards a more general pattern of integrated policy-making involving intersectoral preparation of statutes, stands and programmes.

A comprehensive system of intersectoral apparatus for preparing national stands on EU policy proposals was established when entering the EU. Integrated assessments, including health, are required in all legislative proposals (48, 49). Enacted in 2010, the new Health Act requires municipalities to prepare and discuss reports on their population groups' well-being and health and their major determinants within discussions of municipalities' strategic plans. The Finnish government programme states that "the promotion of well-being and health as well as the reduction of inequality will be taken into account in all societal decision-making, and incorporated into the activities of all administrative sectors and ministries". The intersectoral Advisory Board for Public Health is developing a strategy to make this happen.

South Australia has developed the HiAP approach for its context, putting emphasis on incorporating health high on the government agenda, as well as on written agreements on joint strategic planning and budgeting. A health lens exercise has been used for working with other sectors on initiatives selected and monitored by the Executive Committee of the South Australian government (for details see 50). HiAP implementation is led by a small unit within the South Australia's health ministry (SA Health). However, authority for HiAP rests with the Department of the Premier and Cabinet, giving it the mandate of the head of state and a truly whole-of-government focus. South Australia has also adopted a new Public Health Act (2011) that requires all local governments to develop health plans.

In **Thailand** health impact assessment has been described as a means of resolving conflict between government and civil society (51) – citizens have the right to request an assessment when they have concerns about the health impacts of a government decision. HiAP (including mandated use of health impact assessment) resulted from a popular movement for political and economic reform in the 1990s. Thai Health Promotion Foundation (ThaiHealth) provides a governance structure for HiAP. Chaired by the Prime Minister, the ThaiHealth Board comprises representatives from economic and fiscal, education, agriculture, transport and health sectors (51).

2.7 Conclusions and lessons for policy-makers

This short history of HiAP highlights that achieving coherence in policy in relation to health is not a new aim and has arisen in different contexts. The following key lessons emerge from the history and should be taken into account by policy-makers charged with developing and implementing a HiAP approach.

- Assessing the health and health equity impacts of all sectors is not new and has long roots going back to at least the nineteenth century.
- Public health action, including HiAP, is inevitably a political activity and does not follow a rational linear development process.
- Public health reforms do not happen without political will. Social movements have been instrumental in creating that will – struggling for the right to health and the conditions that facilitate it – and acting as precursors to political and bureaucratic reforms which have improved social and environmental conditions.
- Past comprehensive efforts to improve public health have been undermined by a lack of support from those with power. In global health, important donors have been more eager to support time-bound interventions in which output can be measured and money tracked. Also, the medical community has failed to provide uniform support for interventions that go beyond their professional competence and immediate power.

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Chapter 3

Health and development: challenges and pathways to HiAP in low-income countries

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Key messages

- The complex relationship between health and socioeconomic development means that health determinants are best addressed through a broad development strategy and multisectoral policy engagement.
- A comprehensive development strategy or plan, with health prioritized as a shared goal of public policy, can provide an effective framework for HiAP in development contexts. This requires strong institutional capacities and accountability mechanisms.
- The underlying determinants of health can be addressed through social policies designed to support the structural transformation necessary for development. Such policies fulfil multiple functions – related not only to protection but also to production, redistribution and reproduction.
- The health sector is unlikely to make significant strides towards better health for all in low-income contexts in isolation from a broader development strategy with complementary economic and social policies.
- A sustainable approach to improving health must therefore be embedded in a wider commitment to the pursuit of comprehensive, universal or rights-based social policies backed up by fiscal and redistributive mechanisms.

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3.1 Introduction

Applications of HiAP approaches have been documented principally for more developed economies and systems of government (1–4). As noted in Chapter 2, however, the roots of HiAP can be traced back to lower-income contexts – from the early public health movement in early nineteenth century Europe to the health promotion movement in Latin America in the 1930s, and the initial stage of European welfare state building (2, 5). In such contexts, and often in the absence of a well-functioning health system, major improvements in health occurred through public interventions within and outside the health sector in areas such as water, food and nutrition, sanitation, housing, education and transport.

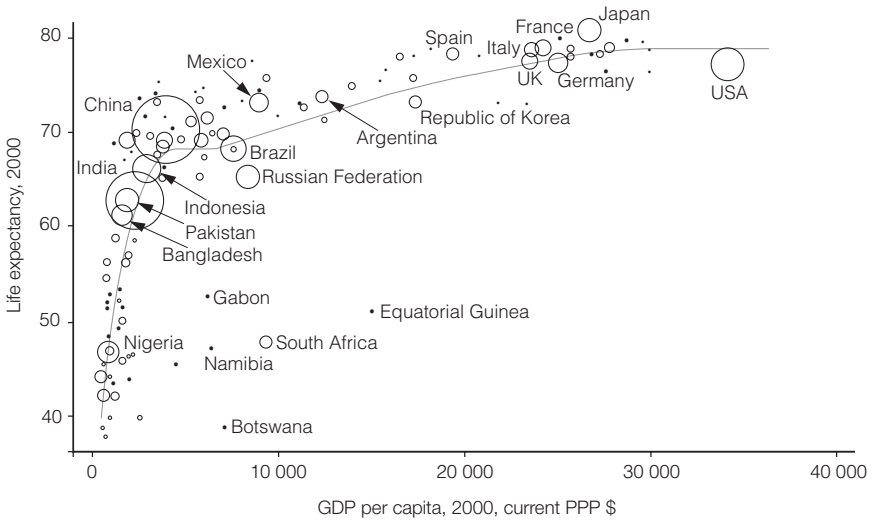
This chapter considers to what extent current approaches to HiAP are appropriate to the conditions of less-developed countries; and how a HiAP approach can be applied and realized in such contexts. Health is generally viewed as an intrinsic 'good' as well as a means to, and an indicator of, development. It is also well-established that health is determined largely outside the health sector. Therefore, it would appear logical that improved population health should be a widely shared goal of public policy, through interventions that address the underlying determinants of health. In practice, documented cases of HiAP tend to refer to societies with a strong health sector; a high capacity for multisectoral coordination; strong societal consensus and political commitment to social goals such as health and well-being; and available financial, human and technical resources (6, 7). Such conditions are often weak or absent in low-income settings.

In such contexts, what policies or mechanisms can address the determinants of health and deliver better and more equitable health outcomes? This chapter outlines the importance of locating HiAP within the broader set of welfare-enhancing public policies. When social policies address a range of functions essential to development, they can play a transformative role in promoting health and well-being as well as other social and economic goals. Having reviewed evidence on the relationship between economic development and health, we consider social policy's role in overcoming constraints to better health in a development context (section 3.2). We then examine key dimensions of any development context (economic, social and political) that shape options for improving health or implementing HiAP (section 3.3). The chapter concludes with a discussion of how social policy can facilitate a strategic multisectoral approach to achieving better health in low-income contexts (section 3.4).

3.2 Health, economic development and the role of social policy

The relationship between health and economic indicators of development is complex. A correlation between average income and population health has long been accepted. Rising incomes are sometimes viewed as a prerequisite for good health (8); conversely good health contributes to productivity and growth while also being intrinsic to other dimensions of well-being (9–11). However, a wide range of intervening factors determine whether or not economic growth or increased incomes lead to better health, and for whom. As illustrated by the Millennium Preston Curve in Fig. 3.1 (12), vastly different health outcomes are achieved among countries at similar levels of income. Examples of poor countries making dramatic health improvements include (at different historical moments) China under Mao, Costa Rica, Cuba, Sri Lanka and Kerala state in India. At the same time, substantial disparities in health outcomes are observed within countries at all levels of income – by income, race, ethnicity, gender, location (rural/urban) or along other lines of inequality or exclusion.

Fig. 3.1 *Economic development and health*



Source: Deaton, 2004 (12). Note: diameters of circles are proportional to population size; PPP$: purchasing power parity dollars.

The literature on health equity and on the social determinants of health has highlighted multiple inputs within and beyond the health sector which determine health outcomes (13–17). Higher personal incomes may improve health by supporting better access to sanitation, decent housing, education and health services (18–20). Education (particularly for females) is strongly

associated with improved health practices and child health (21–24). However, such causal pathways do not translate automatically from individuals to the population. Factors such as gender, age, ethnicity, race, class and location affect inputs into good health, and may create significant inequalities in access to health services and disparities in health outcomes (25–28).

3.2.1 Social policies in development context

Addressing the economic, social and other determinants of health requires interventions outside the health sector – a recognition that underpins any approach to HiAP. The question is what form interventions might take in a development context. Social policies embody the set of values, institutions and processes that shape societal outcomes in any country. At their best, social policies can be transformative in facilitating the structural change or transitions – economic, demographic, epidemiological and social – that are widely shared challenges for developing countries. Well-designed social policies can support the management of structural transformations in ways which enhance welfare, share benefits and create access to essential goods and services for all.

As described by Mkandawire (29), the critical *functions* of social policy in a development context include:

- *protection*, particularly of the poor or vulnerable, from adverse circumstances and contingencies including ill-health;
- *production*, or support for economic development through enhanced human capital and a healthy workforce;
- *redistribution,* reducing inequalities including those of health; and
- *social reproduction,* involving shared responsibility for the care of individuals, particularly children, sick people and elderly people.

Other functions of transformative social policies may include the broader goals of strengthening solidarity and social cohesion; promoting participation and empowerment; and strengthening inclusive and democratic processes and institutions (30).

This transformative social policy approach translates into different policies and programmes according to context. Interventions need to address deficits in material needs; ensure basic living standards; reduce inequalities and exclusions; and aim for a progressive increase in coverage and in the quality and range of services provided (e.g. basic infrastructure, health, education, care services). Access to benefits should be grounded in claimable entitlements. Links to employment through job creation, labour market regulation and

increased productivity are essential for development and for fiscal sustainability. Addressing the care and reproductive needs of any society, including the reproduction of labour, also requires provisions for the inclusion of women in public life and the economy by (among other things) reducing their domestic care burden (e.g. provision of child care). Together, a transformative set of social policies should provide security and promote well-being throughout the life cycle.

Given the role that economic and social factors (income, education, employment, ethnicity, gender, social class, etc.) play in determining health outcomes, the health sector is unlikely to make significant strides towards better health for all in low-income contexts in isolation from more comprehensive social and public policies. Such policies can help to rebalance the unequal distribution of social determinants of health among population groups. In their absence intersecting inequalities tend to reinforce disadvantage, including in the health domain.

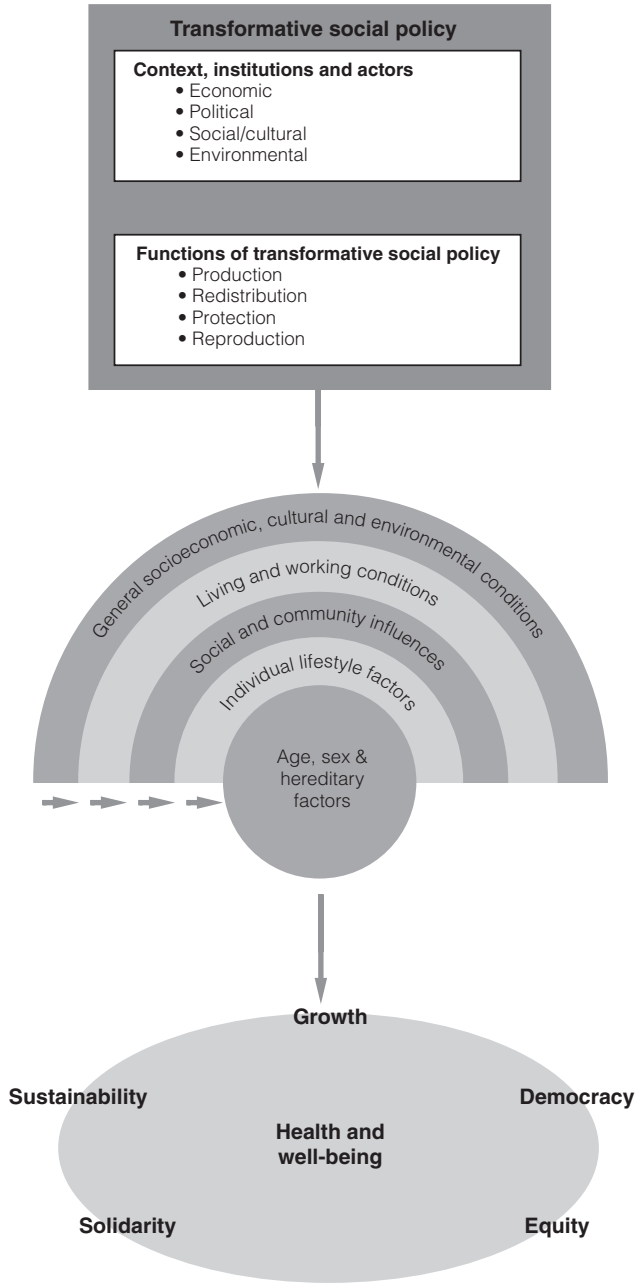
A residual approach to social policy that focuses principally on protecting the poor and vulnerable – or those excluded from or negatively affected by market-led growth – is unlikely to create the wider framework and synergies between economic and social policies that would support the integration of health goals across other policy arenas. Broader social processes and policies thus combine to shape the overall 'regime' of welfare that affects the determinants of health and determines developmental outcomes in any context.

In sum, as sketched in Fig. 3.2, transformative social policy offers a pathway to enhanced health and social well-being – the final goal of HiAP – by addressing the broader socioeconomic, cultural and environmental conditions that underpin health outcomes. Simultaneously, it promotes growth, democracy, solidarity, equity, and sustainability – key dimensions of development.

3.3 HiAP in development context

The key dimensions of a development context likely to shape possibilities for HiAP concern both specific *conditions* (such as poverty rates, level of income and resources) and the *processes* of transformation, including the institutions and actors that shape policies and their implementation. A number of such dimensions and factors likely to be critical in shaping strategic approaches to population health are summarized in Table 3.1 and elaborated in the subsequent discussion.

Fig. 3.2 *Transformative social policy's role in enhancing health and well-being*



Source (for middle illustration): Dahlgren & Whitehead, 1991 (170).

Table 3.1 *Key dimensions and factors of the broader development context*

Dimensions	Factors and examples
Economic	*Level of economic development*: income per capita; growth; poverty rates; distribution of income and wealth.
	Economic structure and profile: structure of economy and employment; urbanization; industrialization; integration into the global economy; aid dependency; fiscal capacity.
	Economic policies and institutions: macroeconomic and employment policies; liberalization; regulation.
Social	*Social relations and structures of inequality*: gender; race/ethnicity; class; religion; location.
	Social policies, institutions, actors: residual, redistributive, universal; regressive/progressive; relative role of state, private sector, other non-state actors and households.
	Social infrastructure and services: level of provision; degree of commercialization; systems of public/private provision and financing.
Politics and governance	*Political regime*: democratic/authoritarian.
	Governance institutions and capacities: mechanisms for transparency, accountability, participation; bureaucratic, technical and regulatory capacities; human, administrative and financial resources.
Demographic	*Demographic profile*: population age structure; fertility rate and trend; population growth; population mobility/migration.
Health and health systems	*Epidemiological/health profile*: life expectancy; maternal and infant mortality; risk factors (e.g. tobacco and alcohol use, poor diet, unsafe water, poor sanitation, hazardous working environment); major disease burdens and their distribution across diseases or socioeconomic groups.
	Health systems: financing, insurance coverage; human resources; private vs. public health service provision systems; surveillance and information platforms; policies and regulations; prevention vs. treatment; health protection.
	Infrastructure for health: sanitation; education; clean water; safe transportation.
	System outcomes: accessibility, affordability, quality and efficiency of health services; health equity.

3.3.1 Economic development: institutions, policies and challenges

In low-income countries, and among low-income populations in many middle-income countries, serious deficits are found in the cornerstones of public health: essential nutrition, sanitation, decent livelihoods, basic care and health knowledge. Experiences in the three decades from the 1950s – a period of dramatic improvements in human health in countries as diverse as Chile, China, India and Tunisia (31) – demonstrated the contribution of widely improved access to nutrition, sanitation, primary care services, education and basic infrastructure. Such achievements were facilitated by government action, often supported by ideologies of solidarity and egalitarianism (32–35).

The rise of neoliberal policies in the 1980s, and their imposition on low-income countries via Washington Consensus conditionalities, was particularly damaging to the social sectors, undermining the broader context for promoting health and well-being for all in many low-income settings (30, 36, 37). Access to, and availability and affordability of, services were compromised as the public sector retrenched, providers were privatized and services commercialized (38). Across sub-Saharan Africa, Latin America and Asia, catastrophic out-of-pocket expenditures soared, the quality of services deteriorated, health systems crumbled and health indicators worsened (30).

Despite some softening of this approach in the 1990s, social policies have remained largely residual with the state's role being principally to address market failures or adverse consequences of market-led development. Despite documented negative impacts on outcomes and equity, the commercialization of social services (including health care) remains largely unchecked (38). Where privatized services or cost-recovery mechanisms are combined with a targeted approach to social policy, the poor are often excluded from services, and health-care costs themselves become a major cause of poverty.

Such policies also weaken the capacity of countries confronting more complex health and demographic challenges. Low and lower-middle income countries increasingly face a costly double epidemiological burden – with infectious and chronic disease burdens both contributing significantly to mortality and morbidity (39). Some countries have younger populations; others face a hollowing out of the working age population through HIV/AIDS; others are entering a phase of rapid population ageing. In all cases the result is a high dependency ratio in terms of healthy workers to the rest of the population, with implications for economic growth, fiscal revenues and the (highly gendered) burden of social reproduction or care for children, sick people and the elderly.

Each developing country also has its own history and development path, giving rise to specific combinations of health challenges. Road safety is a major public health challenge in many rapidly growing countries such as India, Thailand and Viet Nam; smoking is the biggest preventable cause of death in China; and air pollution accounts for major mortality and morbidity in Bangladesh, China, India, Malaysia and Viet Nam. Food and drug safety is a recurring issue in many contexts, as is occupational health and injury. These interrelated health and economic development challenges require actions across different sectors and at multiple levels.

Even under conditions of rapid growth and rising incomes, as in China, the complexity of such challenges becomes evident when we examine the multiple and intersecting exclusions of one significant population group – China's rural to urban migrants (Case study 3.1).

3.3.2 Social institutions and inequalities

Social institutions underpin forms of inequality that shape health problems, access to care and health outcomes. Individuals or groups disadvantaged across more than one domain – gender, ethnicity, location or income, for example – are more likely to experience poor health and limited access to affordable services. This intersectionality (also found in wealthy societies) requires interventions across multiple areas of government policy. Both group and income inequalities have received insufficient attention within the current development agenda centred around the MDGs and the reduction of absolute poverty (41). In many countries the MDG health goals are unlikely to be achieved; part of the explanation "lies in a failure to reach the most vulnerable populations, as advances in national indicators for the MDGs often mask increasing inequities within countries" (42). In other cases, recent years have seen some levelling or even reversals in inequality trends (at least in terms of income). In countries such as Argentina, Brazil, Costa Rica, China and the Republic of Korea (32, 43), governments are taking greater responsibility for welfare through redistributive policies. Social protection is expanding while governments are maintaining or expanding their role in the financing and management of health care and other services such as education, housing and social security.

Gendered institutions provide a powerful example of intersectionality, with particular importance in shaping societal inequality and health outcomes. Educated and healthy mothers make a significant contribution to population health – from prenatal nutrition and early childhood development, women are key to the physical, emotional and cognitive development of their children which affect subsequent life chances (44–46). However, in many low-income settings, girls are less likely to stay in school; more likely to marry young (with higher risks in childbirth); have fewer employment opportunities and thus lower incomes; and bear a disproportionate burden of care for the household and for other family members. Particularly in rural areas, this may involve a significant time burden (collecting fuel and water), exposure to unhealthy cooking stoves and other factors detrimental to health. The significant burden of care and social reproduction, and its implications for the health of women and their family members, remains poorly captured in statistics and policy-making (47). However, such work provides an essential complement to a functioning health-care system.

3.3.3 Governance and state capacity

Ultimately, efforts towards the achievement of substantial improvements in welfare and accompanying reductions in inequality – whether in health,

Case study 3.1 *Addressing intersectoral challenges: internal migration and health in China*

China has experienced rapid economic growth fuelled, in part, by migrant labour from rural areas. In 2009, over 230 million Chinese (or 17% of the Chinese population) migrated. Such mobility has huge implications for the health of the Chinese population, for patterns and burdens of disease, for China's health-care system and other social welfare and public policies.

For **rural-to-urban migrants**, mobility often means increased risk of occupational injury and disease; exposure to infectious disease; poor living conditions; and mental health problems. Migrants are generally excluded from health-care or insurance schemes, or disadvantaged by the non-portability of social insurance; face higher costs of access to care in urban areas; and non-eligibility for many basic services accessible to urban citizens. They face stigma as transmitters of disease to urban populations while often returning to rural areas in ill-health and becoming a burden on their families.

Family members left behind, particularly elderly people and children, may also be deprived of care.

Despite major health implications, migrants have largely been neglected in the major health-care reforms and expansion of insurance coverage and health-care services in recent years.

To address these public and individual health challenges arising from such mobility requires:

- better understanding of the link between mobility, the burden of disease and ill-health;
- public health policies that address migration-related health challenges (e.g. spread of infectious diseases);
- enforcement of labour regulations to reduce occupational health risks;
- equal access to health care and portability of benefits (regardless of residence status);
- access to other social services and benefits, and adequate housing and sanitation, at destination;
- provisions for care of family members (accompanying or left behind), including care and education of children.

Addressing the health challenges of mobility (affecting migrating, urban and left-behind populations) requires a broader social or public policy approach in which the health system is only one among many elements.

Source: UNRISD, 2012 (40).

income or other dimensions – is a political choice (41). It also requires appropriate governance structures and technical capacities. The possibility of welfare enhancing and redistributive policies is shaped by factors such as the nature of the regime (democratic/authoritarian), electoral system, degree of popular participation and institutional arrangements for accountability. The political regime also affects a government's dependence on particular groups; mechanisms for legitimization; control over resources; fiscal and policy space; and capacity for regulation and implementation.

The majority of documented HiAP cases are found in more developed economies or welfare states. These tend to have democratic regimes, transparent and accountable governments, relatively abundant resources and well-developed health systems. In such contexts, governments generally have strong capacities for regulating markets and providers, coordinating social service provision and implementing redistributive policies through the fiscal system or other mechanisms. Thus, they reduce extremes of social inequality and promote the social well-being of citizens. By contrast, in many lower-income contexts the state may have limited capacity either to mobilize resources or to invest available resources for developmental or capability-enhancing purposes. Regulatory capacity with respect to commercial providers, as well as mechanisms of participation or accountability, may also be weak. Such institutions or capacities may therefore need to be built or strengthened as part of a HiAP approach.

A number of cases suggest that countries at varied levels of economic development, and under different political systems, are capable of taking coordinated or multisectoral action to address health (and other social) challenges. Initiatives for intersectoral action vary from large-scale cross-sectoral national actions, primarily in wealthier countries (e.g. Canada, England, Finland, Norway), to group-targeted or local initiatives (for example, addressing the health needs of poor and marginalized sex workers in the district of north Kolkata, India; establishing health services and programmes in Kitgum District, Uganda after conflict) (2, 4).

Nonetheless, complex intersectoral initiatives place high demands on any political system which has to negotiate among competing interests. Negotiations over health reform in the current Indian context provide an example of the complexity of reaching consensus for bold reforms in a democratic society with a strong constitutional commitment to rights, but with high levels of inequality and intense competition between interest groups (48). Even where consensus around political priorities is forged, and decisions are taken by government, implementation requires technocratic capacities in addition to continued political leadership. Thailand's 30 baht health scheme was an important electoral platform for Thaksin in 2001, but depended on the backing of a strong

health system and capable technocrats in the Ministry of Public Health (49). In China, a strong administrative system uses pilot schemes to demonstrate results of new initiatives (e.g. the New Cooperative Medical Scheme) in order to increase political and popular support (50). In such cases the health-sector's role is central to policy success (see also Chapter 14). At the same time, broad consensus over policies; how and whether health priorities become embedded in wider policy and decision-making processes; and how competing claims on state resources are resolved, all take place above and beyond the health sector.

Local government, civil society and nongovernmental actors – including NGOs, media, businesses and citizen groups – also play significant roles in achieving broader social goals. Local initiatives may be critical for addressing social determinants of health while ensuring suitable provision of appropriate social and health services (2). Facilitating alliances between groups; strengthening mechanisms of accountability and participation; and ensuring access to information are important in increasing the provision of public goods (51). Local, bottom-up or targeted initiatives are unlikely to address structural causes of inequality which often underpin poor health outcomes in low- and middle-income contexts. Yet, such initiatives can play an important role in the absence of political consensus on more redistributive and universal mechanisms – and may ultimately be part of the pressure for further reform.

3.3.4 Policies for better health

A wide range of policies beyond the health sector are suggested by the foregoing discussion, with important implications for health and its social determinants in lower-income contexts. These could include initiatives that:

- ensure access to basic conditions for a healthy life – water and sanitation, housing and basic infrastructure and services;
- enhance individual/household incomes through employment creation, adequate wages or remuneration, increasing productive capacities and supporting access to markets;
- protect individuals/households against shocks to income and consumption, including ill-health;
- improve well-being and capabilities through investments in health, education and other services;
- support women's role in the economy and society by sharing the burden of care of children, sick people and the elderly;

- enable citizens' active and informed participation through access to information, and accountable and responsive institutions.

Without necessarily requiring complex coordination, government actions across these different policy domains can link synergistically to support development processes that are also good for health.

3.4 Social policies and health: strategies for HiAP in development context

The broader context of developing countries – including high rates of poverty, complex inequalities, deficits in basic services and infrastructure, weak governance or technical capacities, and limited financial and human resources – creates specific challenges for the implementation of HiAP within and beyond the health sector. But, as already suggested, opportunities exist for policies with shared economic, social and health benefits. Strengthening of the health sector must be an essential component of any strategy. Ultimately, however, an effective HiAP approach in a development context needs to be situated at the level of a comprehensive development strategy or plan in which health is prioritized as a shared goal of public policy.

Transformative social policies (as previously defined) are essential for making a development strategy inclusive and sustainable, and thus addressing deficits in health and well-being in developing countries. The market fundamentalist approach which (with some modifications) has dominated development policy since the 1980s assumes that markets are the ultimate mechanism for the efficient allocation of resources and can thus maximize societal well-being. However, as already noted, the policies associated with this approach (commercialized provision, cost-recovery and targeted social protection, for example) have proven particularly damaging in contexts of high poverty rates and weak administrative systems.

By contrast, evidence from a range of contexts demonstrates the advantages of a more comprehensive approach to social policy. While recognizing the need for interventions that ensure the inclusion of the most disadvantaged, universal basic social provisions tend ultimately to be of better quality, more inclusive, and politically and institutionally more sustainable than those targeted only at the poor (52, 53). Universal schemes are more likely to reduce inequalities and enhance social cohesion. They may reduce administrative and transaction costs for policies (such as HiAP) that require coordination between ministries and sectors, and thus contribute to creating an environment conducive to intersectoral actions for health in low-income countries.

Currently there is renewed momentum towards universal approaches to social provisioning as a basis for more inclusive economic growth, particularly in parts of Asia and Latin America. Different mechanisms, policies and programmes are emerging, with varied combinations of targeted and universal social protection; public and private provision; commercial and social insurance; and financing from general tax revenues. Overall, these initiatives represent a deepening recognition of the interrelationship between multiple factors in the development process, including the need for solidarity-based redistributive mechanisms to ensure a sustainable economy and cohesive society. Progressive expansion of new programmes and their institutionalization in law, policy and budget processes in countries such as Brazil, Chile and Mexico suggests that these shifts will be enduring (54).

At the international level there is also renewed emphasis on expanding basic provisions and moving towards universal coverage. This is seen in efforts to establish a global Social Protection Floor with a set of minimal social guarantees for all. These include basic health care (55) as well as the promotion of universal health coverage, led by WHO and endorsed by the UN General Assembly in December 2012 (56). Both these issues are prominent in ongoing debates around the content of a post-2015 development agenda.

As implied in the earlier discussion of politics, different factors or windows of opportunity may lead governments to move towards more universal, redistributive social policy or health system reforms. While sometimes underpinned by a concern for universal rights, in practice such reforms may be driven by multiple concerns: political legitimacy or electoral gain; management of social unrest; economic considerations, including enhanced productivity through human capital investment as in Sweden in the 1930s and the East Asian developmental states (57, 58), or increased domestic consumption and demand. Whatever the motivation, a universal approach to social policy has usually fostered greater solidarity, social cohesion and coalition building among classes, groups and generations. These are factors that may help combat forms of inequality that contribute to poor health outcomes.

3.5 Conclusion

Health policy is a key battleground in which "competing visions of the ethical and political basis of society, and of the nature of the economy, are fought out" (38). As discussed in this chapter, the complex relationship between socioeconomic development and health requires an approach to health in low-income settings that explicitly recognizes the broad determinants of health status, while also acknowledging that good health is instrumental for achieving

social and economic development goals. The chapter has highlighted key variations in economic, political and social contexts relevant to lower-income economies. Such heterogeneity implies that HiAP strategies must ultimately be context specific – determined by a country's political system and institutions; socioeconomic development level and inequalities; health problems and priorities; and government capacities and available resources.

Even in contexts where health systems are weak and coverage is limited, basic health issues can be addressed coherently within a wider development strategy. Public policies that aim to improve health systems need to be integrated with transformative economic and social development policies that can be more effective in addressing underlying health determinants. Ultimately, policy choices will be driven by the value that society places on equity and health; by the political regime and space to build alliances, control resources and shape a redistributive agenda; and by the capacities of the state at different levels (in collaboration with other actors including enterprises, NGOs and citizens) to advocate, support and implement such policies. Therefore, a sustainable approach to improving health must ultimately be embedded in the state's wider commitment to the pursuit of comprehensive, universal or rights-based social policies, as part of a social contract among citizens, and backed up by redistributive financing mechanisms.

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Chapter 4

Prioritizing health equity

Michael Marmot, Jessica Allen

Key messages

Concerted and coordinated action on the social determinants of health requires strong political leadership and ambition – locally, nationally and internationally. Several factors must be recognized and developed in order to achieve this:

1. Strong public support for action to tackle health inequities provides the necessary legitimacy, accountability and momentum.
2. Cross-government action is needed to tackle social determinants of health.
3. Taking action on social determinants of health brings benefits in other sectors.
4. The economic crisis is a moment for action on health equity, not inaction: analysis has shown that health inequities worsen under economic crisis and austerity. Doing nothing has high costs – financially and in widespread costs to health.
5. Health and other inequities are transmitted between generations. Action is needed to protect current and future generations. Ways of assessing policy for this include health equity in all policies and the development of assessment tools for future impacts on equity.

Implementation of actions, as set out below, is not straightforward but – with sufficient drive, leadership and action across sectors and at different levels – significant reductions in loss of health and life are achievable.

4.1 Introduction

A significant and growing evidence base shows the relationships between health and the circumstances in which people are born, grow, live, work and age. Wide inequities in the distribution of power, money and resources are responsible for differences in these conditions of daily life and associated differences in health and length of life (1).

Evidence demonstrates that inequities in levels of health and life expectancies are unnecessary and unfair. They can be reduced, requiring action at societal level – globally, nationally and locally. Reduction of health inequities should be a priority for governments everywhere as health is an important concern for populations. Action to improve it and reduce inequity is widely supported (2).

Health-care systems can have some effect in reducing health inequities. However, real reductions will come only when all sections of society work together to tackle this unnecessary loss of life and health. It is immensely challenging to achieve collaboration internationally, nationally and locally and in a variety of sectors but, as this book describes, mechanisms are in place and there are many examples of success. Effective coordinated action can be driven by political will and prioritization but sometimes this is difficult to secure, particularly in times of economic austerity and competing priorities.

However difficult the obstacles, political prioritization is essential for reducing health inequities. Strong leadership is needed, particularly from health ministries, in order to ensure that other sectors incorporate health equity in their policies, strategies and actions. Given the importance of delivering health equity in all policies, it is important to forestall anxieties that health in all policies and sectors constitutes a form of health imperialism. Good health is commonly regarded by the public as a high priority and is often a population's greatest concern. In fact, this public concern with health means that reducing inequities and improving population health should necessarily be a priority for all governments across all policy areas. The Task Group on Equity, Equality and Human Rights for the WHO European Review of Social Determinants of Health and the Health Divide (European Review) summarizes this widespread perception of the unfairness of inequity in health and the high value the public places on good health (3).

Despite this public concern and the demands of social justice, economic crises across the world have meant that ambitions for greater health equity have been seen as an unaffordable luxury, even by those governments and organizations which previously prioritized action. This is particularly worrying; tackling health inequity should be of even greater urgency during economic crises and austerity.

Poor economic conditions lead to worse health and greater inequity and there are high costs associated with doing nothing to tackle them. For example, evidence from England shows that illness associated with health inequalities accounts for productivity losses of £31–33 billion per year; lost taxes and higher welfare payments in the range of £20–32 billion per year; and additional National Health Service (NHS) health care costs well in excess of £5.5 billion per year (4). In England, estimates of the waste of life and health resulting from people not living as long or as healthily as the best-off indicate that people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed a total of between 1.3 and 2.6 million extra years of life (5).

These high individual and financial costs are likely to increase through recession and austerity. The WHO Regional Director for Europe commented on the European Review:

> The review demonstrates that the European economic crisis and the response to it have adversely affected the social determinants of health. In today's Europe of economic difficulty and austerity, we must nurture health as a resource for everyone in the Region to prevent these inequalities from worsening (6).

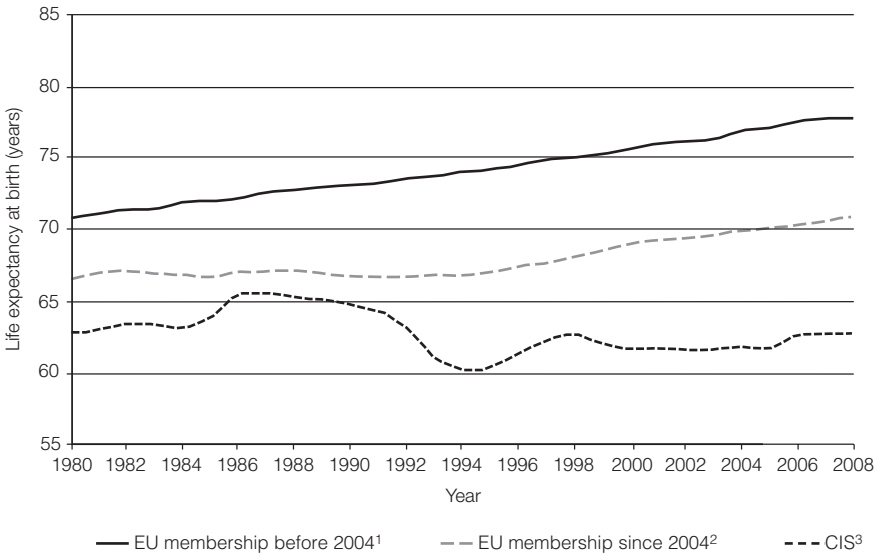
The CSDH was set up in 2005 in response to growing concern about persistent and widening global health inequities. In this chapter we describe some of the actions to reduce health inequities which have followed publication of the CSDH's final report in 2008. We also present evidence and policy recommendations assembled during the 2010–2013 European Review (7). Such reviews are conducted with the aspiration that many of the recommendations will be taken up, adapted to local contexts and implemented. Some examples of implementation of the CSDH's findings are discussed in this chapter. It is hoped that gathering interest and concern across the world – combined with practical, appropriate action at many levels in different sectors – will help achieve widespread impact to reduce health inequity and to foster the necessary political and public will.

4.2 Health inequity and causes: problems and emerging approaches

Socially cohesive societies – affluent, with developed welfare states and high-quality education and health services – have created conditions that enable many people to lead lives they have reason to value. These have resulted in remarkable health gains, although distributed unevenly throughout the population. Moreover, not all countries have shared fully in this social, economic and health development. For example, social and economic circumstances have improved

in most countries in Europe but differences between countries remain. Health inequities between many countries in Europe are increasing. Fig. 4.1 and Fig 4.2 depict data up to 2008 but the severe economic crisis will likely have further widened health inequity (8).

Fig. 4.1 *Trends in male life expectancy in EU Member States and CIS, 1980–2008*

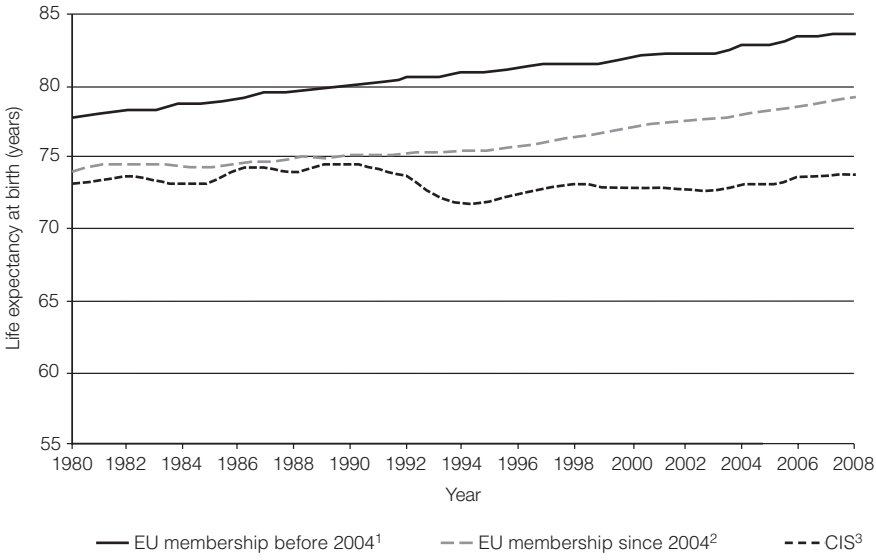


Source: WHO European Health for All database, cited in (9). [1] Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and United Kingdom. [2] Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia. [3] at the time of data collection the CIS consisted of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

Persistent health inequities exist within all countries and may also be widening, even in those that are more affluent (5). The CSDH drew attention to dramatic social gradients in health seen within most countries. For example, everyone in England has seen health gains but these have not been distributed equally and health inequities continue to widen. In London there is as much as a 17-year difference in male life expectancy between Tottenham Green (a deprived area) and Queens Gate Ward (a wealthy area) (5). In Glasgow, Scotland, there is a 28-year difference between the most deprived and the least deprived areas (10). These health inequities are not confined to poor health for some people and good health for everyone else, they are distributed along a social and economic gradient.

As already discussed in this chapter and Chapter 1, such social class inequities relate to inequities in social, economic and political spheres – factors such as inequities in employment and working conditions, quality of early years

Fig. 4.2 *Trends in female life expectancy in EU Member States and CIS, 1980–2008*



Source: WHO European Health for All database, cited in (9). [1] Austria, Belgium, Denmark, Finland, France, Germany, Greece, Ireland, Italy, Luxembourg, Netherlands, Portugal, Spain, Sweden and United Kingdom. [2] Bulgaria, Cyprus, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Malta, Poland, Romania, Slovakia and Slovenia. [3] at the time of data collection the CIS consisted of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan.

experiences, education levels and places where people live, travel and work. Evidence from the CSDH and the European Review shows some of the key issues in understanding and promoting health equity. These are summarized in Box 4.1 (1, 5).

New approaches and recommendations to tackle health inequities across Europe were developed during the European Review. This is based on the approaches formulated in the CSDH, with a particular regional focus and based on most recent evidence and analysis. The evidence produced in the European Review has led to proposals for a broad range of actions to tackle health inequity under four themes — life course stages, wider society, the macro-level broader context and systems of governance. These broad themes are summarized in the following paragraphs; the more detailed recommendations for action are described in the European Review's main report and background papers from the task groups (7).

1. **Life course stages** – advantage or disadvantage begins before birth, in the conditions through which people experience pregnancy, birth and quality of early years; education; working age; and older age. Actions must tackle the cumulative impact of disadvantages (and support the accumulation of advantageous experiences) which result in unequal distribution of health

Box 4.1 *Key issues in understanding and promoting health equity*

• There is a social gradient in health (i.e. health is progressively better the higher the socioeconomic position of people and communities). It is important to design policies that act across the whole gradient, as well as addressing those at the bottom of the social gradient and who are most vulnerable. Achievement of both these objectives will require policies that are universal but with attention and intensity proportionate to need – proportionate universalism.

• The social determinants of health (e.g. conditions in which people are born, grow, live, work and age) must be addressed as these components are key determinants of health equity. In turn, these conditions of daily life are influenced by structural drivers: economic arrangements, distribution of power, gender equity, policy frameworks and the values of society.

• Advantages and disadvantages in health and its social determinants accumulate over the life course. This process begins with pregnancy and early child development and continues with school, transition to working life, employment, working conditions, and circumstances affecting older people.

• Processes of exclusion should be addressed rather than focusing simply on addressing the characteristics of excluded groups.

• Strategies and actions should be developed based on the resilience, capabilities and strengths of individuals and communities. The hazards and risks to which they are exposed need to be addressed.

• Much focus has been, and will continue to be, on equity within generations. The perspectives of sustainable development and the importance of social inequity affecting future generations means that intergenerational equity must be emphasized. Actions and policies' effect on inequities in future generations should be considered and action taken to reduce potential adverse effects.

• All the social determinants of health can affect genders differently. In addition to biological sex differences, fundamental social differences exist in the way that women and men are treated and the assets and resilience they possess. In all societies, these gender relations affect health to varying degrees and should shape actions taken to reduce inequities.

Source: Marmot et al., 2012 (2).

across populations according to social and economic factors. The highest priority must be early intervention by countries and work to ensure a good start to life for every child.

2. **Wider society** – creating the conditions which lead to societal cohesion and mutual responsibility between individuals, communities and countries.

One of the more tangible ways to achieve these is through adequate and increasingly ambitious levels of social protection, distributed according to need. It is essential to encourage cohesion and resilience at local level, including developing partnerships with those affected most by inequitable conditions and processes. This includes approaches based in human rights legislation and protocols, particularly the right to health.

3. **Macro-level context –** every region has wider influences (within and between countries) that shape the lives, human rights and health of people. The health effects of the recent economic crisis provide the most practical example, indicating the need to recognize the health and social consequences of economic austerity packages. Health equity in all policies is a useful approach and development of fiscal policies should include the views of ministers for health and social affairs at a transnational level, WHO, UNICEF and the ILO.
4. **Systems of governance –** improvements in health and its social determinants will not be achieved without significantly refocusing delivery systems to whole-of-government and whole-of-society approaches. The starting-point is the health system – what it does itself and how it influences others to achieve better health and greater equity. This requires achievement of greater coherence of action across all sectors (policies, investments, services) and stakeholders (public, private, voluntary) at all levels of government (transnational, national, regional, local). Universal access to health care is a priority – where this is established, it is to be protected and must be extended progressively to all countries in the Region.

Building on previous work on social determinants of health, including the CSDH and the Marmot Review, some new approaches to tackling health inequities have emerged from the European Review (11).

4.2.1 Human rights

Human rights embody fundamental freedoms and the societal action necessary to secure those freedoms. In other words, society's wider influences on the social determinants of individual health are of fundamental importance in enabling people to achieve the capabilities that lead to good health (12). The right to health entails rights to equity in the social determinants of health. Hence, human rights should be central to action on the social determinants of health. As Venkatapuram has argued, the right to health should be understood as a moral claim on the capability to be healthy. This capability to be healthy is largely shaped by the social determinants of health (13).

4.2.2 Action in a challenging economic climate

As suggested in the introduction to this chapter, economic crisis is not a time for inaction. In fact, the imperative for action is strengthened: investment in early child development, active labour-market policies, social protection, housing and mitigation of climate change will help to protect populations from the adverse effects.

The CSDH, Marmot Review and the European Review all argue the moral case for action. In many areas, the moral and the economic case for action coincide. As outlined above in relation to England, health inequities are hugely costly in economic as well as human terms. Also, preventing health inequities by investment in early child development and education for instance, could meet the demands of both efficiency and justice. Furthermore, action on social determinants of health leads to other benefits for society which, in turn, may have more immediate economic benefits. For example, a more socially cohesive, educated population is likely to have lower rates of crime and civil disorder; a more highly skilled workforce; and can enable people to lead lives they have reason to value, with better health and greater health equity.

4.2.3 Intergenerational transmission of inequity

The European Review demonstrates that much inequity is transmitted through generations. Policies should therefore be assessed for their impact on subsequent generations – an intergenerational health equity impact process. Evidence assembled for the European Review (and elsewhere) clearly demonstrates that children's early development, life chances and, ultimately, health are strongly influenced by the social and economic background of their parents and grandparents; location, culture and tradition; education and employment; income and wealth; lifestyle and behaviour; and genetic disposition.

Furthermore, morbidities (e.g. obesity and hypertension) as well as behaviours that put health at risk (e.g. smoking), recur in successive generations. Sustainable reduction of health inequities requires action to prevent relative and absolute disadvantage of parents being passed to their children, their grandchildren and subsequent generations. The strongest devices to break such vicious circles of disadvantage lie at the start of life. The recommendations of the European Review address key factors contributing to the perpetuation of health inequities.

4.3 Making it happen? Implementing the recommendations of the CSDH

The final report of the CSDH had the ambition to influence policy and to

foster a social movement, and the Marmot Review was a direct sequel. Both reports lay out clear recommendations. The editor of *The Lancet*, Richard Horton, congratulated Michael Marmot on leadership of the two reviews but regretted that too little had happened. This was addressed in the paper which forms the basis for the second half of this chapter. Published in *The Lancet* in 2011, *Building of the Global Movement for Health Equity: from Santiago to Rio and Beyond* points to significant and encouraging developments on social determinants of health (14). So, it appears that both views are right – there has been a good deal of action on social determinants of health, but not enough; a great deal of discussion, but insufficient action; compelling examples of good practice, and significant policy lacunae.

If the expectation is that a commission report will largely be ignored, that most certainly has not been the case with the CSDH. This chapter will report evidence of its ramifications, along with the Marmot Review and (it is hoped) the European Review. However, it would be unreasonable to expect a direct read-across from a report to a set of policies as policy rarely works that way. Becoming part of the policy discourse is clearly a benchmark of success, even if difficult to measure.

The evidence assembled by the CSDH has led to much support for action to reduce unnecessary loss of life and loss of healthy life experienced across the world, but much more is needed. In addition, many of the responses to the global financial crisis have slowed progress. Hosted by the Government of Brazil and WHO, the World Conference on Social Determinants of Health provided an opportunity to do more to galvanise support, prioritize action and respond to the CSDH's call for social justice as a route to a fairer distribution of health. Held in October 2011, the goals of the Rio Summit were to report on progress since the CSDH and stimulate further global and national action on social determinants of health and health equity. The conference culminated with Member States' acceptance of the Rio Political Declaration on Social Determinants of Health (15). This expresses global political commitment for the implementation of a social determinants of health approach to reduce health inequities and to achieve other global priorities. It is hoped that this commitment will help to build momentum for the development of national action plans and strategies.

4.3.1 Experiences of action on the social determinants of health

A strength of the CSDH recommendations lay in their global reach – a call for all countries, and relevant global actors, to take action. But this global reach also posed challenges as it was difficult to formulate recommendations that were simultaneously appropriate, for example, for sub-Saharan Africa and North

America or northern Europe. The CSDH strived for a level of recommendation somewhere between high-level aspirations and impossibly detailed. The former would be worthy but might not help in advancing action; the latter would be more concrete but too voluminous and difficult for a global commission to formulate. Making a virtue of necessity, the CSDH argued that (as with the Rio Declaration) countries should use *Closing the Gap in a Generation* to develop local action plans, using local evidence and mechanisms for policy development and monitoring. Much has happened and some actions are described in the next section.

Conversely, many observers see a less positive picture arguing that social determinants of health have barely penetrated the global agenda – for example, health equity is hardly a consideration in trade talks; governments are too diverted by the global financial crisis and their domestic economic problems to give focus to health equity; the default position of people in the health sector is to focus on health services and prevention of specific diseases. What the CSDH described as a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics is all too evident in some regions of the world. Related to this is the gap between rhetoric and performance in which corruption plays a major role.

Many countries have explicitly embraced social determinants of health. In addition, a great deal of policy action relevant to social determinants of health may not have been labelled as such – many other countries may have initiatives like those in India (Case study 4.1). The recommendation to hold a global summit was partly driven by the need for accounting of action in all countries as well as a spur to further action. In Africa, where the need is great, countries such as Kenya and Mozambique have expressed interest in social determinants of health. In Europe, and the Americas, action on the social determinants of health is better developed than in other regions. This may reflect stronger political will in many countries, based on a longer history of social welfare and social justice; a more extensive evidence base on causal relationships between determinants and outcomes; and more extensive monitoring data.

The global financial crisis adds urgency to consideration of the dramatic financial inequities, within and between countries, which preceded it. As standards of living decline in many countries, and government revenues are squeezed, it can be argued that there is even greater urgency for all policy decision-making to have regard to distributional impacts.

4.3.2 Examples of prioritization of action on the social determinants of health

There are many examples of action on the social determinants of health to achieve greater equity; some are described briefly here.

United Nations Development Programme (UNDP), in collaboration with Michael Marmot, is developing a social determinants of health approach to NCDs.

Pan American Health Organization (PAHO) has prioritized social determinants of health and health equity. Social determinants of health are on the agenda for all WHO Regions. WHO organized and ran the Rio Summit in 2011 which resulted in commitments to take forward action and review developments.

There are several country/region specific examples.

Chile – Ministry of Health review on how its policies fit the CSDH recommendations.

Argentina – appointed Vice-Minister of Health with responsibility for health equity.

Brazil – implemented Brazilian National Commission on Social Determinants of Health and co-organized World Conference on Social Determinants of Health.

Costa Rica – implemented whole-of-government approach to tackling health equity.

South Australia (Australia) – initiative from WHO and South Australia: the Adelaide Statement on Health in All Policies (see 16).

The Asia Pacific network of the Global Action for Health Equity Network (AP-HealthGAEN) – regional collective progressing the health equity agenda (7).

Alberta (Canada) – Provincial Government is actively developing a social determinants of health programme. There is ongoing interest in a social determinants of health approach in work with indigenous people's health in Arctic Canada.

New Zealand – Development of a social determinants of health approach in public health.

Peru – The Mayor of Lima's health strategy is influenced by the CSDH.

Case study 4.1 *Initiatives in India*

In India, there is some interest in creating a network for social determinants of health. This would serve to prioritize action on the social determinants of health and allow the collaboration and cross-sector activity required for effective action.

Other examples include:

Civil society

Self Employed Women's Association (SEWA) – an organization and movement representing poor, self-employed women workers (17).

Government initiatives

- rural employment guarantee scheme;
- food security bill;
- consideration of restructuring the Integrated Child Development Services;
- health-care expenditure related to action on the social determinants of health to rise from 1.2% to 3% of GDP;
- plans to extend coverage of social security for informal workers;
- extending the right to education;
- plans to improve housing and basic infrastructure for the urban and rural poor.

Anti-corruption

- Widespread demonstrations called for strong anti-corruption legislation following Anna Hazare's hunger strike in April 2011 when government talks broke down.
- Government has accepted Hazare's revisions to the Jan Lokpal Bill, a proposal to establish an independent anti-corruption body (18).

Source: Mirai Chatterjee, personal communication.

Several countries and transnational organizations (e.g. WHO European Region and the EU) have been active in Europe.

The WHO Regional Office for Europe commissioned the European Review to feed recommendations on social determinants of health into the process of the new health strategy – Health 2020. The review will provide analysis and recommendations for action on health inequity for international, national and

local governments and organizations across a range of social, cultural, political and economic sectors. Chaired by Michael Marmot, this wide-ranging, two-year review will report in 2013 (7, 12).

The EU has commissioned several reviews of evidence and action on health inequalities for consideration of actions to describe, monitor and tackle health inequalities and inequalities in the social determinants of health across the EU.

The Lancet and the University of Oslo (UiO) jointly established The Lancet - UiO Commission on Global Governance for Health.

In addition many countries in Europe have taken action locally and nationally.

- *Norway* – policies to address the social gradient in health, heavily influenced by the CSDH.
- *Denmark* – review of social determinants of health (19).
- *Sweden* – city of Malmo has set up a commission based on social determinants of health (20).
- *Slovenia* – committed to cross-government action based on a recent report (21).

Case study 4.2 *England: the Marmot Review and developing social determinants of health approaches*

Following publication of the CSDH report in 2008, the English Government commissioned a review of health inequalities and actions to reduce them, chaired by Michael Marmot. Much has followed publication and widespread dissemination of the review findings published as *Fair Society, Healthy Lives* in early 2010.

In 2011, the Government issued a public health white paper (22) with a social determinants of health focus, putting reduction of health inequalities at the centre of its strategy. Much was based on, or a direct response to *Fair Society, Healthy Lives* (5). This report had six domains for recommendations.

1. Give every child the best start in life.
2. Education and lifelong learning.
3. Employment and working conditions.
4. Minimum income for healthy living.
5. Healthy and sustainable communities.
6. Social determinants approach to public health.

Case study 4.2 *contd*

The English Public Health Outcomes Framework contains a tranche of indicators under social determinants of health along with other public health indicators, directly influenced by *Fair Society, Healthy Lives* (5).

Action at subnational level includes plans to tackle health inequity across London, the North West, and the Yorkshire and Humber Regions, and plans for other regions. More than 75% of local authorities in England have developed action plans and strategies based on the Marmot Review.

In 2012, legislation introduced a set of new health inequality duties throughout the English health system, effective from April 2013. This new legislative framework currently applies to the Department of Health and NHS organizations but, if these duties are upheld, may facilitate the prioritization of health equity throughout the health system. An across-government legislative approach would have even greater power and impact.

4.3.3 Features of good governance for health

The European Review contains a wealth of evidence, information and proposals for action. However, as outlined earlier in this chapter, the required scale of action will not happen without political will and prioritization. Every level of governance needs arrangements that are capable of building and ensuring collaborative joint action and accountability for health within health and non-health sectors, public and private organizations.

Box 4.2 reproduces a description from the European Review of essential features of governance for health systems required to address the social determinants of health (2).

As discussed throughout this book, improvements in health and its social determinants need delivery systems refocused towards whole-of-government and whole-of-society approaches. This requires greater coherence of action across all sectors and stakeholders (public, private and voluntary), at all levels of government (transnational, national, regional and local). The health system is critical in achieving this – in health service delivery, health improvement and tackling inequities *and* in influencing other sectors and stakeholders to achieve better health and greater equity. This requires ministers of health to assume a greater leadership role and increasing prioritization of action in preventing ill-health by reducing harmful health behaviours and improving health protection systems.

Box 4.2 *Effectively addressing the social determinants of health: essential features of health system governance*

- High level of political will and commitment – globally, nationally and locally.
- Transnational mechanisms that promote health and equity (e.g. accountability mechanisms that are transparent and are based on empowerment).
- Equity in all policies.
- Appropriate levers and incentives.
- Institutional readiness.
- Collaboration and action from key stakeholders.
- Rights-based approach.
- Community involvement (draw on and strengthen capabilities and assets).
- Cross-sectoral and partnership working (embedded in existing management and performance systems).

Source: Marmot et al., 2012 (2).

4.4 Conclusions

Concerted and coordinated action on the social determinants of health requires strong political support and drive at local, national and international levels. For this sort of political will, the issue must be prioritized. We have argued that there are many ways to achieve this prioritization.

Firstly, public support for action to tackle health inequities means that action should be prioritized by governments at all levels. A human rights approach to equity in health and social determinants of health supports this view and is a means of achieving prioritization.

Secondly, recognition that cross-government action is needed to tackle social determinants of health. This involves an acceptance that health inequity is closely related to inequity in the social determinants of health. Evidence and advocacy to achieve a whole-of-government approach are significant, and the audience for arguments supporting prioritization of action on social determinants of health should not be confined to health ministers. Involvement should be government wide – fostering health equity in economic policy is a clear example.

Thirdly, recognition that taking action on social determinants of health will bring benefits in other sectors – for instance, reducing inequities in education and early years or fostering mitigation of climate change. If one set of policies

is more likely than another to cause a greater drop in living standards for those on low incomes than for those on high, predictably it will have an adverse impact on health equity. If a set of policies widens the educational divide or employment opportunities along the social gradient, predictably it will have an adverse impact on health equity *and* on other desirable societal outcomes as discussed. Social cohesion; an educated population; good employment and working conditions; and policies that foster processes of social inclusion will be good for health and for society as a whole.

Fourthly, recognition that the economic crisis is a moment for action on health equity, not inaction: analysis has shown that health inequities worsen under economic crisis and austerity. The costs of doing nothing are high – financially and in widespread costs to health.

Fifthly, recognition that health and other inequities are transmitted between generations. Action is needed to protect current and future generations. Ways of assessing policy for this include health equity in all policies and the development of assessment tools for future impacts on equity.

It is hoped that evidence presented in recent reviews (outlined here and elsewhere) concerning the scale of health inequities; their causes; and practical suggestions for prioritizing and tackling them, will resonate and lead to greater political prioritization. Certainly, there is evidence of this happening across the world as a result of the 2008 CSDH and across the United Kingdom of Great Britain and Northern Ireland as a result of the Marmot Review. Implementation of actions is not straightforward but with sufficient ambition, leadership and action across sectors and at different levels, significant reductions in loss of health and life are achievable.

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Chapter 5

Globalization and national policy space for health and a HiAP approach

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Key messages

- Global policies and international agreements in non-health sectors can restrict national policy space for health. Ministries of health need to ensure consultation processes and to participate effectively in, and understand better, what is being negotiated and how this affects policy space for health.
- National policy space can be enhanced by utilizing fully the policy space in existing international agreements. This requires: (i) understanding and making full use of exceptions and flexibilities in existing trade and investment agreements; (ii) invoking national and international legislation on health-related human rights; and (iii) strengthening and, where necessary, expanding existing health-related treaties and agreements so as to enable scope for regulation for health.
- Key messages from national experiences include: (i) identify national health policy interests; (ii) enhance openness, transparency and participation of wider civil society with due consideration of conflicts of interests; (iii) seek to ensure that government priorities in trade policy negotiations are set within broader policy-making and accountability, and that health-related issues are raised in this context; (iv) ensure that health ministry has capacity and sufficient knowledge on issues related to trade and investment policy and their relationship to health, particularly differing views or priorities

between health and trade policies; and (v) increase global exchange, training and communication across health ministries in the area, with the facilitation of WHO.

5.1 Introduction

HiAP can refer to policies and policy decisions at any level that such decisions are made. Health is generally considered to be a concern of national governments but contemporary globalization requires them to pay due attention to the negotiation processes of international treaties and foreign policy decision-making as these affect national policy space – "the freedom, scope, and mechanisms that governments have to choose, design and implement public policies to fulfil their aims" (1). Global economic integration can influence policy space within both the health sector and the health-related regulation sectors that influence health and social determinants of health.

In this chapter the primary focus is globalization as an economic process, involving the *mobility of goods, capital, people and services* which is governed by the *global regulatory framework on trade and investment and global economic institutions and policies*. The growth in global operators and mobility – as well as in international rules, regulations and rights that accompany global economic integration – have direct relevance to regulation for national health policy purposes. Perhaps the best known example is the impact of bilateral and multilateral agreements on intellectual property rights and related measures on access to highly priced new medicines for the treatment of HIV/AIDS.

Often, globalization is characterized as a process that reduces the role and powers of national governments. Other analyses emphasize that "the response to globalization can be said to begin at home", drawing attention to the role of national policy decisions in shaping global economic and trade policies (2). Globalization – and the many bilateral, regional and multilateral rules (treaties, conventions, norms) that constitute the basis for its governance – need to be understood as outcomes affected by national-level decision-making; governments' foreign policy prioritization; international negotiation involving diplomacy and power-brokering; and the resulting constraints that internationally negotiated agreements impose on national-level decision-making.

Consideration of globalization's economic and regulatory effects on policy space for health requires examination of two frameworks: (i) international agreements, including those on trade and investment; and (ii) economic policies chosen (or defended) as responses to globalization and the demands of increased global competitiveness, and that affect fiscal policy space. So far, migration

and international mobility has taken place largely outside the influence of international trade agreements. In this chapter migration is addressed only in relation to health tourism and health professional mobility.

5.2 International policies and national policy space for health

This chapter is concerned with the potentially health-negative effects of international constraints on national policy space, although international constraints may also have positive health consequences. For example, international human rights treaties can be invoked or, when adopted as part of national legislation, used by HiAP proponents to constrain national government policies that violate human rights obligations in ways that are harmful to health. Similarly, international health treaties (e.g. International Health Regulations (IHR); WHO FCTC) guide national measures on health protection and can oblige or encourage national governments to achieve improved health outcomes. International labour and environmental standards and conventions seek to impose or enable certain government policies or regulations that often have health-promoting effects, even if health is not the primary outcome of concern. These treaties represent opportunities to advance HiAP within countries, given the normative power they represent. Formal dispute mechanisms and economic penalties attached to trade and investment treaties create enforcement mechanisms which support compliance but are still lacking for most other health-promoting global treaties.[1]

5.3 Trade and investment agreements and policy space for health

It is often argued that economic liberalization and trade expansion benefit health by generating income and creating wealthier societies (5). However, evidence of these effects remains mixed (6, 7). It is more relevant to HiAP that governments' trade and economic policies for stimulating economic growth may not contribute to improved health. They can worsen health inequities by creating greater economic and labour market insecurities or by increasing socioeconomic disparities (8–10, see also Chapters 2 and 3).

1 The WTO has a mechanism for dispute settlement which is empowered by allowing trade sanctions for correction of measures. Only governments may use this mechanism, although many complaints arise from pressure and concerns of domestic or global industries. Investment agreements can include provisions for arbitration mechanisms, which can be brought up by corporations on the basis of principles used in commercial arbitration. United Nations Commission on International Trade Law (UNCITRAL) rules have been used for arbitration of commercial disputes (3).However, provisions on arbitration in investment treaties are expanding these practices to disputes with public policies, consequently principles of commercial and private arbitration are now used more for arbitration between corporations and governments (4).

Concern over the constraints that trade and economic treaties place on national policy space is not new. The importance of governments preserving economic policy space in trade treaty negotiations (particularly the relationship between trade and development) was explicit and debated intensely at the 2004 United Nations Conference on Trade and Development (UNCTAD) (11). A basic goal of all trade liberalization agreements, tariff reductions can affect national health policy by reducing fiscal capacities. This is especially true for low-income countries that rely on tariffs for a large portion of their public revenue and have insufficient alternative methods of taxation to offset tariff reductions (12, 13). For example, the South Centre estimated that economic partnership agreements being pursued by the European Community would result in Kenya and Mauritius bearing tariff revenue losses that would exceed their entire spending on health (14).

Since the establishment of the WTO, trade policies have extended beyond border measures (such as tariffs) to affect national policy space more directly. Trade agreements and negotiations now focus on intellectual property rights and data exclusivity; services; sanitary and phytosanitary measures; government procurement and investments. Such treaties reach much further into domestic regulation and national policy-making. Furthermore, they apply not only to health-related regulatory measures and impacts on social and environmental determinants of health in other sectors, but also to policies and regulation *within* the health sector.

Several WTO dispute settlement cases have focused on national policies concerning tobacco and alcohol. Under trade rules based on national treatment (i.e. like products from another country cannot be treated differently to domestic products), dispute panels so far have invariably ruled that differential taxes on imported cigarette products are trade discriminatory. However, this ignores evidence that increasing the supply of an unhealthy commodity for which pricing is of importance (e.g. tobacco) generally leads to price competition and increased consumption (15). Regulatory efforts to restrict advertising services or presentation of trademarks on packaging are also likely to be subject to trade treaty disputes. In Australia, the introduction of plain packaging has been challenged in the context of a bilateral investment treaty; Ukraine, Honduras and the Dominican Republic have sought the WTO dispute settlement process for claims based on trademark violations under the WTO Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS Agreement). Packaging and labelling requirements can also be challenged under WTO rules, with consequences for how governments can tackle NCDs (see Case study 5.1.)

Case study 5.1 *Traffic light labelling on snack food products in Thailand*

Since 2007, a network of health-related organizations has attempted to implement traffic-light labelling (rather than labelling based on, often difficult to understand, nutritional content) for snack food in Thailand. This approach has been endorsed by several domestic and international paediatricians' associations.

In 2009, the National Health Assembly (NHA)[2] agreed to develop a strategic plan on overweight and obesity. Traffic-light labelling was identified as one of three main measures but the Thai Food and Drug Administration decided to use monochrome guideline daily amounts (GDAs) instead. This decision was widely viewed as reflecting the influence of the food industry rather than based on technical information and social support. Efforts to introduce food labelling in Thailand also became a matter of discussion within the WTO Committee on Technical Barriers to Trade in 2008. In 2009 the United States report on foreign trade barriers (16) noted how, when "the United States and other countries raised concerns about [Thailand's] proposed requirement…[for] 'traffic light' labeling logos on five categories of snack foods" the proposal was withdrawn and replaced with a message for people to consume less and exercise more. Even that non-controversial message led United States' trade policy officials to argue that it raised "many of the same concerns" due to the potential impact on trade (16).

Trade-related aspects of intellectual property rights, investment, government procurement and trade in services are likely to become of greater concern for HiAP. These behind-the-border agreements (i.e. not simply tariffs but a range of public policies that can affect trade indirectly) can have extensive impacts on national health policies and, for example, how governments regulate and contain costs of health services or use pharmaceutical licensing and pricing policies to ensure access to necessary medicines.

Multilateral trade negotiations take place under the auspices of the WTO. Binding dispute settlement mechanisms and the use of trade sanctions to enhance compliance have enhanced the legal relevance of WTO agreements. However, as multilateral negotiations move very slowly, many countries are engaging in bilateral or plurilateral negotiations to extend commitments made under WTO or add new areas such as government procurement and investments. These are

2 Established by the National Health Act in 2007, the Thai NHA is a forum for formulation and follow up on participatory healthy public policies. It consists of more than 200 constituencies and more than 1000 participants from government, civil society organizations and communities, health professional councils, the private sector and academia. The National Health Commission (chaired by the Prime Minister) appoints the NHA Organizing Committee (NHAOC) with a requirement that the NHA is held at least once per year. The NHAOC chair serves as President of the NHA for a two-year term of office. The first president was from government and the second from academia; the current president is from the private sector.

important areas for HiAP given their impacts on national policy space and government powers to regulate and distribute resources.

Investment agreements have become an increasing concern due to their potential to limit public regulatory measures for health. Generally bilateral agreements, these treaties also form part of regional trade treaties (e.g. North American Free Trade Agreement). They are intended to promote foreign investment by providing certain guarantees to foreign investors, including the right to seek compensation if new public regulations are perceived to expropriate their assets or investments, including intellectual property rights. Unlike WTO disputes (which only governments can initiate), investment agreements with these investor-state provisions allow private companies to sue governments if they consider that the terms of the treaty are being violated. For example, tobacco multinationals are using such provisions to challenge directly Australia's public health requirement for plain packaging as part of its tobacco control measures. The tobacco industry has claimed that plain packaging is contrary to provisions in an investment treaty between Hong Kong and Australia, leading to a call for compensation through investment arbitration[3] (see Chapter 10 on tobacco).

The specific case of tobacco also highlights the broader relevance of potential conflicts of interests between governments seeking to reduce consumption of particular hazardous-to-health products and the corporations and investors benefiting from their sale. States have a legitimate right to regulate in the public interest without paying any kind of compensation (18) but this is contested in investment treaties if regulatory policies are likely to undermine, deter or substantially limit expected profits from an investment. Threats of compensatory claims from corporations may deter governments from tightening regulatory requirements even when they would be legitimate.

While trade-dispute rulings can challenge public health measures to control exposure to unhealthy commodities, they can also offer opportunities to strengthen domestic public health measures. The United States of America attempted to ban the importation of clove-flavoured cigarettes from Indonesia, arguing that flavoured cigarettes are more popular with teenagers and therefore in conflict with the goal to reduce adolescent smoking. The appellate body report upheld the panel decision that, by allowing menthol flavouring in its domestic brands, the American ban on imported Indonesian clove-flavoured cigarettes was clearly discriminatory (19). HiAP proponents in the United States of America now face the challenge of using the WTO ruling to advocate for a ban on menthol flavouring.

3 A recent WHO document describes the background of plain packaging measures, the WHO FCTC and how the tobacco industry has used investor-state arbitration as part of its lobbying tactics (17).

Trade-related intellectual property rights directly affect markets and the prices or availability of generic medicines. The stated purpose of these measures is to enhance innovation through the creation of exclusive monopolies but it is difficult to direct the focus of innovation, particularly for products that have limited markets such as medicines for diseases of the poor (20, 21). Discussions and debates on trade and health at global level have so far been dominated by a focus on access to medicines. However, lack of innovation and support for innovation for antibiotics and treatment of neglected tropical diseases have also gained international attention (21, 22).

The Doha Declaration on the TRIPS Agreement and Public Health sought to clarify the relationship between trade-related intellectual property rights and public health (23) – reinforcing the interpretation of the TRIPS Agreement's provisions for the benefit of public health and the grounds and scope for governments to issue compulsory licenses (Box 5.1). More extensive 'TRIPS+' provisions have been negotiated in bilateral and regional trade treaties by the United States of America and the EU. These can further limit generic production and price competition through new provisions such as data exclusivity[4] or limits on compulsory licensing. In addition, it is important that trade-related policies on counterfeiting[5] do not undermine markets and legitimate trade in generic medicines.

5.3.1 Emerging trade and health intersections with implications for HiAP

One new area in services trade is medical travel or health-care tourism in which patients travel to another country expressly for health care. Often, developing countries promote such trade as a potential source for economic growth (through foreign currency earnings, technology transfers and other spin-off benefits in tourism and related sectors) but it can have problematic repercussions on national policies and policy options. The most immediately worrying aspect of medical travel is the potential for returning patients to spread highly resistant hospital infections (24). There are also concerns over regulating the growth in medical/health tourism to ensure development of universal coverage for, and accessible access to, health care for those living in the low- and middle-income countries in which governments and/or private health facilities are attempting to recruit high-paying international patients (25–27). For a HiAP approach,

4 Provisions allow drug companies to withhold product testing data used to license their patent drug for several years after patent expires, slowing production of generic equivalents and thereby extending their monopoly.

5 Apply primarily to trademark issues, although counterfeiting measures may also include patent infringements. Measures are primarily trade-related and can have positive impacts on health when they limit substandard products. However, they are not sufficient to address the main health-related problem of substandard and falsified products as these may not infringe trademarks or patents.

Box 5.1 *Doha Declaration on the TRIPS Agreement and Public Health*

Paragraphs 4 and 5 of the Doha Declaration contain the most important elements clarifying interpretation of the TRIPS Agreement.

4. We agree that the TRIPS Agreement does not and should not prevent members from taking measures to protect public health. Accordingly, while reiterating our commitment to the TRIPS Agreement, we affirm that the Agreement can and should be interpreted and implemented in a manner supportive of WTO members' right to protect public health and, in particular, to promote access to medicines for all.

   In this connection, we reaffirm the right of WTO members to use, to the full, the provisions in the TRIPS Agreement, which provide flexibility for this purpose.

5. Accordingly and in the light of paragraph 4 above, while maintaining our commitments in the TRIPS Agreement, we recognize that these flexibilities include:

   a. In applying the customary rules of interpretation of public international law, each provision of the TRIPS Agreement shall be read in the light of the object and purpose of the Agreement as expressed, in particular, in its objectives and principles.

   b. Each member has the right to grant compulsory licences and the freedom to determine the grounds upon which such licences are granted.

   c. Each member has the right to determine what constitutes a national emergency or other circumstances of extreme urgency, it being understood that public health crises, including those relating to HIV/AIDS, tuberculosis, malaria and other epidemics, can represent a national emergency or other circumstances of extreme urgency.

   d. The effect of the provisions in the TRIPS Agreement that are relevant to the exhaustion of intellectual property rights is to leave each member free to establish its own regime for such exhaustion without challenge, subject to the MFN and national treatment provisions of Articles 3 and 4.

Source: WTO, 2001 (23).

the challenge is to ensure that the economic benefits of attracting international patients to (generally) private facilities are not at the expense of public health-care access, especially for low-income citizens (see Case study 5.2.)

The migration policies of high-income countries and improvements in the health and medical education institutions of many low- and middle-income countries have increased the flow of health workers from poorer, under-

Case study 5.2 *Trade in health services in Thailand*

Thailand has been one of the most popular destinations for medical services for over a decade. This development of medical tourism resulted from the oversupply of services in private hospitals – having grown rapidly during the previous decade the 1997 economic crisis left insufficient demand from Thai nationals. A number of private hospitals closed, many more reduced capacity and some turned to foreign patients in order to remain economically viable. The Thai Government now actively supports development of the country as the regional medical hub in policies formulated through both the Prime Minister's office and the Ministry of Public Health.

Income generation is one of the main reasons for a country to promote medical tourism but negative consequences also occur. The major concerns are migration of skilled and experienced specialists from the public to the private sector, thereby increasing health-care costs for the local population. Ethical concerns include the growth of tiered health systems. Yet, unlike other countries in the region, Thailand has not experienced the problem of external brain drain. There is an argument that medical tourism will help to attract Thai health workers presently employed abroad to return to Thailand but as yet there is no evidence of this.

The main public and HiAP concern with medical tourism is the competition for limited health resources, particularly since the per capita treatment resources are much greater for foreign patients than for Thai nationals. The key requirements are development of an appropriate plan for human resources for health production, management and retention in order to recover the losses caused by medical tourism; development of the information system to monitor the movement of human resources for health influenced by medical tourism; consideration of using fiscal measures to reallocate income gain from medical tourism to mitigate health impact; and establishment of a public–private partnership on resource sharing for training of human resources for health, especially in shortage fields. All of these will need support from other government sectors (30).

resourced countries to wealthier nations (28). Health benefits for recipient countries are often offset by losses to source countries, even in countries that have developed deliberate policies for the export of trained health workers to enable remittances and to reduce domestic unemployment. The need for global cooperation in managing these flows is reflected in the WHO Global Code of Practice on the International Recruitment of Health Personnel, adopted by the 63rd World Health Assembly on 21 May 2010. The Code seeks "to establish

and promote voluntary principles and practices for the ethical international recruitment of health personnel, taking into account the rights, obligations and expectations of source countries, destination countries and migrant health personnel" (29).

Finally, government capacities for regulation apply not only to publicly funded services and contracts and their relation to global commercial law, but also to largely unregulated areas of medical travel and tourism in the private sector. This includes addressing illegal practices, such as trafficking and trade in organs, as these are likely to be motivated by lower or no regulatory oversight.

5.4 Fiscal policy space and securing sustainable financing for health

Fiscal space refers to government's capacity to provide additional budgetary resources for a desired purpose without any prejudice to the sustainability of its financial position (31). Fiscal policy space for health applies to the extent that governments can use fiscal policies to fund health, influence consumer behaviour through taxes or address social determinants of health. In essence it is about how governments raise and spend money, and how spending on health (or on areas affecting social determinants of health) is constrained by competing demands for public financing. Many high-income countries are seeking to constrain growth in their public health-care spending – sometimes by pursuing greater private-sector involvement. At the same time, many low- and middle-income countries are expanding public coverage, including public provision (32), supported by renewed international attention in health as an 'investment' in achieving other development goals, and as an important end in itself (33, 34).

Health-related consumption taxes and fiscal measures play an important part in health policy priorities concerning NCDs. This is reflected in the United Nations Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, and in WHO global strategies on diet and nutrition, alcohol and tobacco (see Chapter 1). However, implementation of fiscal measures for the purpose of health policy is often restricted by priorities in other sectors, challenged in the context of trade policies or opposed by ministries of finance, trade and industry. Negotiating policy space for such use of fiscal measures is an important challenge for the practice of HiAP. It is also an area where global policies and priorities can support or suppress these efforts. International measures (such as the WHO FCTC) can be an important tool for low- and middle-income countries seeking to implement regulatory and fiscal measures that are against

the interests of major industries – although, as noted, this also means paying close attention to current or proposed trade and investment treaties.

Many European countries facing a current fiscal crisis are implementing or negotiating higher taxes on unhealthy commodities, as are many middle-income countries. In 2012, Thailand approved an increase in both alcohol and tobacco excise tax that should generate substantial new revenues while reducing both the number of smokers and alcohol consumption. Thailand established the ThaiHealth Promotion Foundation (ThaiHealth) in 2001 to support and develop health promotion programmes. Receiving annual revenues of approximately US$ 100 million from a 2% levy on tobacco and alcohol excise taxes, ThaiHealth supports health promotion programmes and projects. Working with civil society and communities to support the development of healthy policies, ThaiHealth also engages in capacity building to address social determinants of health affecting Thai people.

Efforts to increase fiscal space for HiAP are now being challenged by the global financial crisis which quickly became first a global (un)employment crisis (as consumers stopped consuming) and then a fiscal crisis (as governments went deeply into debt to shore up the international banking system and provide economic stimulus). The immediate cause of this crisis was unregulated, excessive and highly leveraged bank lending leading to unsustainable asset bubbles (35). When this system began to collapse in 2007/2008, following three decades of trade and investment liberalization, the increased integration of global 'real' and 'financialized' economies led to recession in much of the world.

Affecting most of the world's nations, the 2007/2008 financial crisis was the first to both emanate from, and profoundly affect, high-income countries. In Europe the first study on mortality trends following the crisis demonstrated statistically significant short-term changes (36). There has been an average rise in suicides, reversing a decade of steady declines. Countries with greater rises in unemployment rates appeared to have larger increases in suicide rates: Greece and Ireland had the greatest increases between 2007 and 2009 – 18% and 16%, respectively. In several countries, the rise in suicides pre-dates the rise in unemployment, indicating the role of economic insecurity and fear of unemployment as a major risk factor. Consumption of unhealthy, low-price foods has risen but, conversely, road traffic fatalities have fallen and alcohol and tobacco use has reduced as incomes have fallen. However, harms may not be reduced if amounts of alcohol consumed per time (binge-drinking) increase (see Chapter 11).

Several European countries have reported steep health budget cuts (some by over 20%) and user charges for certain health services have been instituted to address revenue shortfalls (37). A recent study further confirms that the scope of austerity is quickly becoming severe and global – 70 developing countries (55% of the study sample) reduced total expenditures by nearly 3% of gross domestic product (GDP), on average, during 2010; 91 developing countries (over 70% of study sample) were expected to reduce annual expenditures in 2012. The biggest cuts are anticipated in Latin America and the Caribbean, north Africa, south-west Asia and sub-Saharan Africa. It is particularly disconcerting that comparison of the 2010–2012 and 2005–2007 periods indicates that nearly one quarter of developing countries appear to be undergoing excessive contraction, defined as cutting expenditures below pre-crisis levels in terms of GDP (38).

Yet, financial crises do not necessarily imply or invariably demand policies that worsen social protection through austerity or privatization. The Republic of Korea's financial crisis in the 1990s was associated with a number of progressive social policy reforms rather than retrenchment (39). Austerity programmes (the austerity agenda) imposed or undertaken as a result of financial or economic crises are not simply matters of sufficient resources – they represent political choices of governments, international investors and development funders on what is perceived to be healthy economic development, and how governments should raise and allocate revenue. Alternatives to austerity do exist and can form a basis for a HiAP approach to the present fiscal crises facing many countries.

Finally, while rarely addressed within the public health agenda, the failure of international policies to control tax avoidance, transfer pricing practices and capital flight are also relevant to public resources and policies and, consequently, to the potential for a national-level HiAP approach. An estimated US$ 23–32 trillion in personal wealth sits in low-tax or tax-free offshore financial centres (tax havens) (40). Also, illicit capital flight from developing countries far exceeds the amounts received in development assistance (41). These practices reduce countries' fiscal space. While the scope for unilateral action remains contested, governments can initially act unilaterally to plug these fiscal holes, or seek more limited international cooperation to do so. One such example currently under discussion is implementation of a financial transaction tax – a small charge on foreign currency trades that can be used to regulate trading practices in financial markets (42). Revenues raised through such taxation could also be used to enrich investment in social protection, education and health. This could help to mitigate economic insecurity associated generally with globalization and specifically with financial crises.

5.5 Maintaining and enhancing policy space for health in a globalizing world

It is possible to maintain policy space for health in a globalizing world but this is unlikely to be realized if left only at national level, without a focus on international trade and economic policies. Furthermore, it is likely that ministries of health across different countries will have a common interest in working towards maintaining policy space for health at the national level. The scope to retain or expand policy space for health exists through various mechanisms:

1. working towards better consideration of health within trade and economic policies and national policy priorities at national level;
2. utilizing existing global commitments and treaties;
3. negotiating health-driven normative guidelines and treaties; and
4. engaging in global and national processes which are supportive to health policies and social determinants of health.

5.5.1 Improving consideration of health as part of economic and trade policies

Public health already plays a special role in trade agreements, with substantial global attention on health-related aspects in the context of access to medicines and research and development financing. Intergovernmental working group negotiations on public health, innovation and intellectual property led to a global strategy and plan of action under WHO, emphasizing the inclusion of representatives of health ministries in trade negotiations (20). However, the practice and capacities to achieve this are often a challenge. Firstly, health ministries may not be invited to join, or included within, the formulation of national trade policy priorities. Secondly, they may lack the capacity and knowledge to act swiftly on specific negotiation stances. Where intersectoral cooperation has been taken further it has led to the appointment of specific committees and background work in health ministries. The National Health Act in Thailand set initially the National Health Commission, chaired by the Prime Minister. The Commission established a National Committee on International Trade and Health Studies, chaired by a leader from the Thai Chamber of Commerce. This comprised all stakeholders required to provide background information and study the implications of international trade policies for health systems in 2010. The Thai National Health Assembly has passed a substantial number of resolutions on trade policies – of 40 resolutions

adopted in the first 4 years, 17 relate to trade and 12 have international trade-related components.

In Finland, subcommittees bring together different ministries for routine work. However, a key to maintaining policy priorities in relation to health and trade has been establishment of a parliamentary stand on trade, which takes up health-related concerns. The establishment of the parliamentary negotiation stand was influenced by broader civil society campaigning. Trade policy consultations with participation from civil society were thus important for bringing up health and social policy considerations with parliamentarians. In Canada, popular support for the universal public health insurance programme has allowed the country to withstand repeated efforts to open the programme to competing private models such as those found in the United States of America (its major trading partner). Canada has also retained parliamentary and all-party commitments to withhold liberalization of services trade in public health, education and social protection programmes within trade treaty negotiations.

There is a history of consultative processes between government sectors and with civil society organizations, with several strong civil society organizations working on globalization, trade and health policy issues. The globalization and HiAP lessons from the processes of Canada and, especially, Finland and Thailand can be summarized as:

i) know where health policy interests are;

ii) enhance openness, transparency and participation of wider civil society in contrast to only stakeholder industries;

iii) seek decision-making on wider forums to guide trade policies as part of broader political decision-making and accountability, and ensure that health is discussed in this broader context;

iv) recognize that a knowledgeable and informed ministry of health backed by political will is more useful for a ministry of trade in the longer term, even where there are different policy priorities;

v) increase global exchange, training and communication in the area of trade, innovation and investment so that ministries of health may learn from experiences in different countries and better understand common challenges and opportunities.

While it is possible to increase awareness at national level alone, there is a need for international cooperation, exchange and technical support through WHO to ensure that Member States have adequate knowledge and capacities to address trade-related health issues. Furthermore, global cooperation and action can be

important in allowing and legitimating policy space for national government action for health, as shown in the context of tobacco (see Chapter 10).

5.5.2 Better utilization of existing legal guidance and treaties

The first step towards enhancing national policy space can be made by utilizing fully policy space that already exists. This requires: (i) understanding and making full use of exceptions and flexibilities in existing trade and investment agreements; (ii) invoking national and international legislation on health-related human rights; and (iii) strengthening the right to regulation in the context of existing health-related treaties and agreements such as international health regulations and the WHO FCTC. The Doha Declaration provides a clear example of efforts to utilize the scope within an existing trade agreement for public health benefit. The Declaration clarifies provisions of the TRIPS Agreement that can be invoked for the benefit of public health and is an explicit recognition of governments' rights to regulate, in particular, through issuing of a compulsory licence. Human rights and health-related rights have also become important parts of global diplomacy in recent years, particularly in the context of HIV/AIDS policies. Other global conventions on health-related rights, such as the CRC, can also be particularly relevant (see Chapter 6).

5.5.3 Strengthening global normative guidance and improving its utilization at national level

Health-related norms and treaties can be an important means of securing space for national policy, particularly in relation to multinational industries. Global norms can range from voluntary-based guidelines to formal commitments contained in WHA resolutions (e.g. WHO Code on the International Recruitment of Health Personnel; WHO/UNICEF International Code of Marketing of Breast-Milk Substitutes); binding regulations (e.g. IHR); and the negotiation of binding treaties which need ratification (e.g. WHO FCTC). Global strategies can also give further guidance – for example, the Global Strategy and Plan of Action on Public Health, Innovation and Intellectual Property negotiated in detail by an intergovernmental working group. Governments may also negotiate regional agreements – for example, the Council of Europe's Medicrime Convention is a binding international instrument in criminal law on the counterfeiting of medical products and similar crimes involving threats to public health (43).

There is no reason why compliance with international agreements concerning (for example) investors' rights should have priority over commitments concerning (for example) government capacities to fulfill obligations on human

and social rights, labour rights or the rights of the child. It is therefore important that governments ensure that foreign and commercial policy agreements do not conflict with other commitments. For example, the EU has a treaty commitment to ensure a high level of health protection in all policies on the basis of Article 168 of the Lisbon Treaty (see Chapter 2).

Alliances with other sectors facing similar pressures from trade and commercial policies can be important. For example, many aspects of public health policies link to environmental policy concerns in relation to investment agreements, particularly measures for investment protection. There are some similar issues of concern in the field of trade in services with education and social services. Likewise, a variety of issues relate to labour conditions and occupational health and safety. Exploration of common interests with other sectoral policies at national level can be seen as part of necessary strategic thinking for HiAP, as is allocating time and human resources for sufficient understanding of the legal framework of trade and investment agreements and their interpretations.

Political declarations can also be important in legitimating national action in a particular area, by signalling agreement on policy priorities. For example, political declarations on HIV/AIDS and on NCDs were adopted in the United Nations General Assembly and by the country delegations that issued the Rio Political Declaration on Social Determinants of Health in 2011 approved by the World Health Assembly in 2012 (see Chapters 2 and 4).

Scope for national policy space in health in the context of HiAP is also likely to benefit from global commitments within other sectors – for example, the Millennium Declaration set global commitments with relevance to governance. In turn, the MDGs focus attention on particular health matters but also support health through action on broader policies such as education, nutrition, water and sanitation, and gender equality. Ensuring a strong health voice in current negotiations for post-2015 development goals, through national governments or civil society organizations, is an important example of a global HiAP approach. Health and sustainable development policies have substantial co-benefits; health has been part of the global agenda for sustainable development since the initial Rio Conference in 1992 (44) (see Chapter 11).

Finally, the ILO's global normative work, particularly in occupational health and social security, has importance for health (see Chapter 7). In conjunction with United Nations Children's Fund (UNICEF) and United Nations Department of Economic and Social Affairs (UN DESA), ILO's leadership in the global Social Protection Floor Initiative (calling on and providing guidance to governments concerning implementation of basic income, health and other social security measures) and the ILO Declaration on Social Justice for a Fair

Globalization are particularly relevant for proponents of national-level HiAP (45). Adopted in response to the work of the World Commission on the Social Dimension of Globalization, the Declaration addresses social protection and extending social security for all as one of the organization's four strategic objectives (see Chapter 3).

5.6 Conclusions

HiAP is an elusive target if health priorities are compromised by regulatory requirements set outside the health sector. Furthermore, if HiAP activities remain at local or national level only, the approach is likely to have little capacity to address decisions made on other (notably international) levels of governance. It is therefore important that health ministries are aware of health-relevant policies in other sectors, not only at national level but also at regional or global level.

Global policies and legal agreements in other sectors can restrict policy space for health at national and local levels. Ministries of health need to know where and how this can take place in order to ensure effective contributions to respective consultation processes. Taking advantage of existing global commitments, normative and legal frameworks and, where necessary, negotiating new normative guidance for health can be important for maintaining the scope for HiAP at local and national levels. Ministries of health will need greater awareness and understanding of how health regulation may be affected by legislation and agreements negotiated in other sectors. In addition, they will need to actively guard against decisions in other sectors that may limit or undermine policy space for health or limit policy options within the health sector, including cost-containment for health services and pharmaceutical policies.

Policy space for health is not automatic but set within the context of the overall principles and practice of governance. Participatory approaches and transparency can be elementary in expanding and securing existing policy space for health as well as in ensuring that health priorities are not undermined without due consideration and public debate.

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Part II

Chapter 6

Promoting equity from the start through early child development and Health in All Policies (ECD-HiAP)

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Key messages

- Promoting healthy early child development (ECD) is important for social development and well-being; ECD constitutes a social determinant of health.
- The first five years of life constitute a window of opportunity for investment in and effective promotion of ECD.
- Enough evidence is available on how to set priorities in public policies to promote ECD in terms of reducing health (including NCDs) and social problems.
- Cost-effective policies to promote healthy ECD include the provision of time (e.g. maternity leave), services and resources.
- Disparities in health and human development increase with early, multiple and cumulative risks along the lifespan. Creating positive nurturing conditions and opportunities can reduce existing inequities.
- New social accountability initiatives should consider the burden of responsibility of policy-makers promoting early child development and Health in All Policies (ECD-HiAP) in terms of the social costs of not

intervening with active policies towards the promotion of equity from the cradle.

- There is a need to integrate time (life course), contexts (social determinants) and actors (across sectors) for effective policies towards equity from the cradle. This constitutes a new paradigm tackling the intergenerational cycle of poverty perpetuation.
- Every child deserves the right to develop and be healthy. States have the mandate to respect, protect and fulfil this right.
- As a component of HiAP, ECD has the capacity to be a transformational tool for improving our societies.

6.1 How does ECD relate to adult health and quality of life?

The early years of life are crucial in influencing a range of health and social outcomes across the life course. It is known that many challenges in adult society regarding NCDs – such as mental and health problems, obesity/stunting, heart disease, associated behavioural problems and delinquency and violence – have their roots in early childhood. ECD and child survival share similar social determinants and solutions: both demand intersectoral and integrated policies.

Inequalities in child health and developmental outcomes trace an impressively linear socioeconomic gradient. Overall, child mortality levels correlate closely with income quintiles, with those in the lowest income brackets being affected most severely (1).

From the perspective of children, the world shows a complex scenario of disparities (2).

- ECD is important in all countries, resource-rich and resource-poor, but special attention needs to be paid to the potential benefits to the latter in which a child has a four in ten chance of living in extreme poverty.
- 10.5 million children die before age 5.
- Developing countries have 559 million children under 5 years of age – including 155 million who are stunted and 62 million who are not stunted but are living in poverty.
- Over 200 million children under 5 years of age are at extreme risk of impaired cognitive and social–emotional development.
- Most of these children at extreme risk – 89 million – live in 10 countries that account for 145 million (66%) of the 219 million disadvantaged children in the developing world.

- The loss of human potential represented by these statistics is associated with more than "a 20% deficit in adult income and will have implications for national development" (3).
- Gender differences start in the early stages of life and are expressed through the underprivileged treatment of girls (e.g. school enrolment, differential parenting roles, stereotyping, discriminatory practices), particularly in low-income countries. In itself this is a great obstacle to overall development.

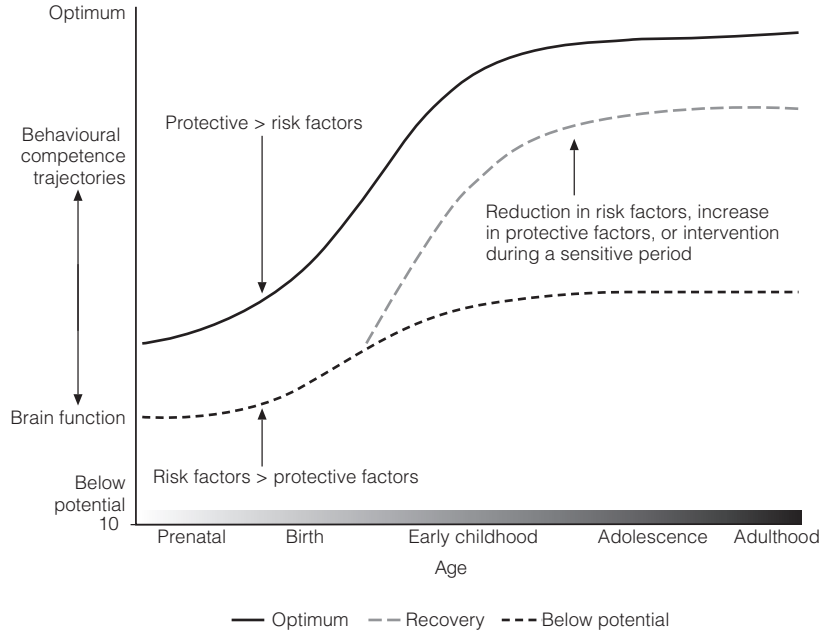
There is increasingly robust biological evidence to account for the manifest links between socioeconomic inequalities and gradients in health, behaviour and cognitive development across the lifespan (4). These relationships take root in, and are conditioned by, patterns of experience during early childhood. They depend upon associated determinants of child health, including maternal health, fetal and neonatal nutrition and nurturing.

The field of epigenetics – the study of heritable changes in gene function that occur without alterations to the deoxyribonucleic acid (DNA) sequence – has exposed the dynamic interplay between biology and society, challenging dichotomic conceptions of nature versus nurture. Recent evidence suggests that the social environment has a profound impact upon the function of a person's genes, providing the context and stimulus for the variable expression of an inherited code. Brain development is the quintessential case in point: early experience appears to exert a critical and lasting influence on neuronal development, suggesting the potential for marked neural plasticity (5, 6).

Evolving knowledge of neural epigenetics and the impact of early experience has profound implications for the understanding of child health and development. The manner in which social milieu moulds development over the life course is only now coming to light, but the awareness that biology is implicated and adapted in this process is transformative. If sensitive-period experience shapes developmental opportunities throughout the lifespan, it has the capacity to engender durable and heritable patterns of vulnerability to adverse health and developmental outcomes. The lasting effects of early experience condition equality of opportunity, both into adulthood and across generations. Knowledge of this fact has arguably redoubled the importance of mitigating disparities in social circumstance as a means to attenuate enduring patterns of health inequality (7).

Exposure to biological and psychosocial risks affects the developing brain and compromises the development of children. Inequalities in child development begin prenatally and in the first years of life. With cumulative exposure to developmental risks (8) disparities widen and trajectories become more firmly established (Fig. 6.1).

Fig. 6.1 *Development of inequalities*



Source: Walker et al., 2011 (6).

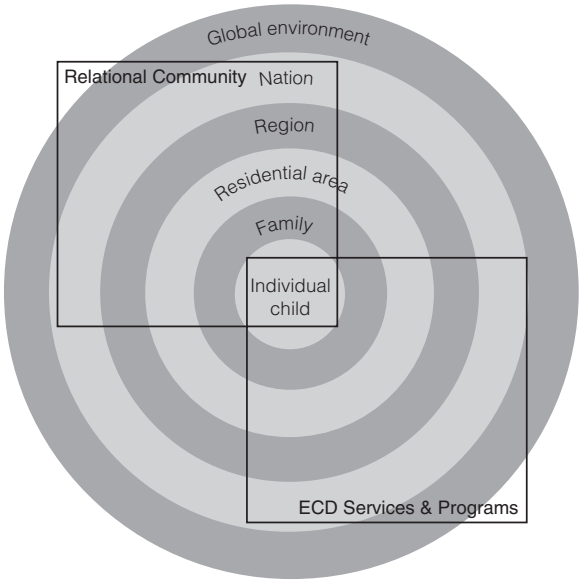
6.1.1 Child-oriented policies can improve people's lives and well-being

A healthy start in life gives each child an equal chance to thrive and grow into an adult who can make a positive contribution to society. In contrast, it becomes increasingly difficult to create a successful life course if the window of opportunity presented by the early years is missed (in terms of both time and resources).

ECD is a social determinant of health but it in turn is determined by the quality of the environments around the child – from the intimate sphere of the family to the broader spheres of governments, international agencies and civil societies which influence and play a key role in ECD outcomes (Fig. 6.2). Governments can make major and sustained improvements in the quality of environments experienced by children in society by implementing policies that take note of this powerful body of research while, at the same time, fulfilling their obligations under the CRC**.**

Fortunately, policy-makers are starting to understand the need to integrate ECD into public policy agendas. There is recognition of an absolute economic efficiency in investing in early years, and an understanding that the gain is large, with no risk of potential loss if the investment is done properly. The evidence from research on early years is so convincing that there is an emergent

Fig. 6.2 *Spheres of influence on ECD*



Source: Irwin, Siddiqi & Hertzman, 2007 (10).

agreement among economists that the most cost-effective human capital interventions occur among young children. James Heckman, Nobel Laureate in Economics, argues: "A major refocus of policy is required to capitalize on knowledge about the life cycle of skill and health formation and the importance of the early years in creating inequality in America and in producing skills for the workforce" (9).

A key question is: which policies should countries consider implementing to improve the situation? Investment in ECD does not require a series of arcane policies but, rather, initiatives in a wide range of relevant sectors that are connected to reinforce each other. At the national level, comprehensive and intersectoral approaches to policy and decision-making work best for ECD, recognizing the importance of contextual factors as both enablers and barriers for policy implementation (see Case studies 6.1 & 6.2 and section 6.2). Although ECD outcomes tend to be more favourable in rich countries, countries such as Cuba have exemplary ECD success and tell a different story. It is clear that a commitment of 1.5–2.0% of GDP, intelligently deployed, can effectively support ECD (15). The UNICEF Innocenti Report Card is testimony to this claim. Providing a comparative analysis of the status of early childhood education and care in the top 25 affluent countries, the report ranks Scandinavian countries highest (15). Closer consideration reveals that Denmark spends 1.2% of GDP on ECD, and Sweden spends close to 2% of GDP on all preschool and school-aged children (11, 15).

Family-friendly policies and practices clearly benefit children and families but also result in economic benefits to larger society. Globally, those societies that invest in children and families in the early years –rich or poor – have the most literate and the largest populations. These are the societies that have the best health status and lowest levels of health inequality in the world. Success in promoting ECD does not depend upon a society being wealthy. ECD programmes rely primarily on the skills of caregivers so the cost of effective programmes varies with the wage structure of a society (see Case study 6.1).

Through child- and family-friendly policies, governments must assist families to fulfil their obligations to their children by providing:

- ***time*** *(e.g. adequate paid maternity leave)*
- ***resources*** *(e.g. income assistance)*
- ***services*** *(e.g. high quality ECD child-care and education programmes) to enable families of young children to create healthy and stress-free home environments for children to be born, grow and develop to their full capacity.*

Case study 6.1 *Child and family friendly policies in Sweden*

Within the continuity of policies in a decades-long process of pioneering development of the welfare state, Sweden's approach to early childhood is based on the underlying assumption that the life course of an individual is, in part, determined by the early years. Approximately 1.7% of GDP is invested in early childhood programmes beyond traditional health care, double the OECD average (12). For this investment, Sweden provides a truly universal access system featuring: high-quality, high-coverage prenatal care; near-monthly developmental monitoring in the first 18 months of life such that all vision, hearing, speech/language and dental problems are identified and addressed before the child starts school; universal, non-compulsory access to publicly-funded high-quality early learning and care programmes (attended by 80–90% of pre-school age children) funded and monitored nationally but organized and delivered locally, run by university educated staff; and a gradual transition from play-based to formal learning at school age that serves to avoid privileging January babies and girls or disadvantaging December babies and boys. These programmes and services are complemented by an income policy that brings virtually all families with young children above the poverty line; as well as up to 18 months paid parental leave with incentives for fathers' participation. Internationally comparable outcomes for child development are not available but basic health outcomes are very impressive. By 2008, infant mortality had dropped to 2.3 per 1000 live births (13). Among the OECD countries, Sweden had

Case study 6.1 *contd*

the lowest low-birth-weight rate (4.2% of live births), about half those of the United Kingdom of Great Britain and Northern Ireland (7.4%) and the United States of America (8.2%). This important predictor of child health is significantly determined by the living conditions and health of the mother (14). Finally, by 2008, Sweden was the only country to meet all of ten UNICEF benchmarks for early learning and care (15).

Sweden's comprehensive public system for the early years evolved gradually over several decades, starting with the welfare state reforms of the post-Second World War era. By the 1950s, a consensus emerged that social welfare programmes would never be enough to keep mothers and children out of poverty. Therefore, mothers needed unfettered access to the labour market and policies for families with young children needed to support that goal. This consensus held throughout the period of Social Democratic political domination in Sweden. Each component of the system was developed as resources allowed, buttressed by emerging insights into the importance of the early years and the commitments made under the CRC. In the 'neo-liberal' political era, beginning in the 1980s, the benefits of the system and the underlying social consensus proved difficult to dislodge. Accordingly – across Finland, Sweden, Norway and Denmark – the 'Nordic model' of social policy has mostly survived attempts to undermine it.

The environments in which children grow and develop are not strictly hierarchical but rather are truly interconnected. The family environment is the most intimate level. Residential communities (such as neighbourhoods), relational communities (such as those based on religious or other social bonds) and the ECD service environment exist at a broader level. Each of these environments (where the child actually grows up, lives and learns) is situated in a broad socioeconomic context shaped by factors at regional, national and global level. We now understand that the transactional[1] nature of young children's relationships is far more important for their growth and development than has traditionally been recognized.

Socioeconomic inequalities in developmental outcomes result from inequities in the degree to which the experiences and environmental conditions for children are nurturing. Thus, all recommendations for action stem from one overarching goal: to improve the nurturing qualities of children's experiences in the environments in which they grow up, live and learn. A broad array of experiences and environmental conditions matter. These include those that are

1 Represents people's ability to 'negotiate' different environments (based on an ecological perspective) and make decisions along the life course.

intimately connected to the child, and therefore readily identifiable (e.g. quality of time and care provided by parents and caregivers; physical conditions of the child's surroundings), but also more distal factors that in various ways influence the child's access to nurturing conditions (e.g. whether government policies provide families and communities with sufficient income and employment, health-care resources, early childhood education, safe neighbourhoods, decent housing).

6.2 Implementation of ECD policies

This section provides a brief analysis of significant aspects related to ECD policy implementation that include:

- the importance of shared value and conceptual frameworks
- structures for intersectoral collaboration
- who assumes the leadership process
- importance of participatory mechanisms
- incremental processes
- targeted versus universal policies
- human rights and international legislation to support national policy-making
- monitoring and evaluation tools.

Governments can develop new venues of action through the creation of an interministerial policy framework for ECD that clearly articulates the roles and responsibilities of each sector and their methods of collaboration. It is recommended that governments should also integrate ECD policy elements within the agendas of each sector to ensure that they are considered routinely in sectoral decision-making.

Many countries have ambitious ECD policies with a high-flown conceptual framework and well-defined objectives that are only rhetorical, never leading to action or endlessly at the early stage of the implementation process. The main factor in this is political will.

Public policy implementation is always contested, with many priorities competing for attention, so the strength of the advocacy coalition for children is crucial. Thus, the intersectorality of childhood policies is not only an opportunity to build a broad coalition but also a problem as the constituency for action for children tends to be diffuse in society, not concentrated and

Box 6.1 *Implementation of ECD policies*

Implementation of ECD policies is complex in proportion to its comprehensiveness. In other words, many strategies and actions need to work simultaneously and complementarily in order to achieve objectives involving the child in his/her family and community environments. Some necessary (but sometimes insufficient) conditions should be considered in the implementation process.

1. **Clear goals and objectives** that are feasible to perform.
2. **Defined target population** such as specific age groups, socioeconomic strata, geographical locations, policy type to be implemented (universal or focalized), implementation strategy (progressive coverage), scaling-up time.
3. **Map of identified sectors and participants** involved in policy development in order to seek agreements on sectoral and cross-cutting responsibilities.
4. **Existence of law and legislative and regulatory frameworks** that facilitate resource mobilization give shape to management models and contribute to the sustainability of what is implemented.
5. **Policy relevance** of strategies to be implemented in order to minimize resistance that often exists and to increase the support of interest groups and communities.
6. **Social acceptability** – it is critical to communicate throughout the territory and the population.
7. **Consistent ethical and value frameworks within the policy proposal** in order to prevent double standards and the lack of priority setting.
8. **Implementation costing** – cost-effectiveness studies if possible.
9. **Feasibility analysis** – considering items 1–8.
10. **No false starts** – may undermine credibility and community confidence.

(usually) lacking in resources. Furthermore, intersectoral effectiveness in child policies requires sharing of conceptual, ethical and value frameworks. There are no recipes for implementation, there are as many ways of doing it as there are child policies: dependent on culture-specific, resource and sociopolitical contexts, and the initial situation of every context, among many other elements. Notwithstanding, a rights and equity framework has a globally cross-cutting character that gives coherence to ECD policies and also has the capacity to facilitate mainstreaming for action.

We propose a roadmap to implement child policies that allows analysis of different scenarios and strengthens operationalization of the concept of ECD-HiAP. However, there is a need to recognize that very often the policy process is uneven, complex and even erratic in terms of the factors that affect this process (see Kingdon's framework (16) and Chapter 1).

Among other activities, implementation requires systematization of the information available in a country on: health and development in childhood; socioeconomic conditions; and health- and education-related determinants. This requires knowledge of the current supply and demands of services, gap analysis, quantification of existing resources and potential mobilization of feasible resources during the implementation process.

6.2.1 Who assumes leadership of the implementation process?

It is important to define who will assume the leadership role (whether a ministry or an institutional representative or a high-ranking official): acting as group coordinator and holding an official mandate with clearly defined roles and relations with others. Prevention of competitive scenarios on technical leadership, double standards and power struggles is recommended. Ministries of planning (or their counterparts) are often neutral and offer greater management capabilities for these types of processes. Planning of such an implementation has a national scope, its importance depending on the characteristics of the country (centralized or decentralized). In both cases, integrating ECD-HiAP and forging strategic partnerships is crucial for the process.

The formation of a cross-cutting group is recommended, whether intersectoral, interinstitutional, multidisciplinary or any other variable of interest appropriate for the country (e.g. ethnic minorities' representation, unions, political groupings). This group would be responsible for providing national authorities with the technical guidelines, management model and distribution of resources; as well as the assessment, monitoring and accountability mechanisms. Other important functions include planning the implementation that defines the general plan and specific programmes that must be executed, the times and structures needed and the resources involved.

Horizontal and vertical coordination are key issues in the policy-making process. Hence, although intersectoral policies at state level are needed, intersectoral governance at community level is equally important as this is where real transformations take place. Many programmes are still designed from the top down, without the involvement of user groups, and are likely to be ineffective, of insufficient scope and potentially unsustainable. There is enough evidence to recommend community-building initiatives that increase cohesion, cooperation and interpersonal trust among children and adolescents, especially in communities with low social capital for levelling up the social gradient in children's health (17).

National guidelines are generally implemented after being locally adapted. At this level, apart from providing services, the participants and executing agencies

are close to children, their families and communities. This place is privileged as all sectors provide natural instances of meeting: regional governments or boards, community councils or others.

Governments, policy-makers and practitioners must ensure that children, young people and families across the socioeconomic gradient participate in the design and implementation of policies and interventions in order to ensure that their needs are addressed and they are reached. Many countries all over the world have implemented consultation mechanisms (mostly at municipal level) that bring children and young people into the policy-making process (including Brazil, Chile, Ireland, United Kingdom).

Health is the sector closest to families and children in their early years, making it a natural entry point for health-related and early biopsychosocial development interventions. As the life course progresses, other participants and sectors (such as education) gain more access and responsibility through different forms of child-care, early childhood and pre-school education. It is important that the implementation process acknowledges what already exists, building upon experience to improve what is susceptible of change to conserve effective actions and eliminate those that are ineffective or potentially harmful to children and families (see Case study 6.2).

6.2.2 Proportionate universal policies

The most effective approach for improving the well-being of children and young people is to ensure their family or caretakers' ability to nurture them. This is best achieved through universal policies that redistribute societal resources but universal policies do not entail policies applied uniformly. To ensure that universal measures effectively level up the socioeconomic gradient, governments should first assess and address the specific pathways that lead to bad health in different socioeconomic groups and across their life courses. For example, the effects of multiple disadvantages may inhibit the ability of disadvantaged families, children and young people to benefit equally from certain universal measures. Universal policies should therefore be designed to address proportionally greater need with greater intensity and/or link service fees or taxes to ability to pay. In addition and where necessary, universal measures should be complemented by targeted measures such as well-designed programmes to prevent early school exits, in order to ensure that children and young people and families in most need get the necessary support (17).

Case study 6.2 *Chilean child protection policy "Chile Crece Contigo" (Chile Grows With You)*

One of (former) President Michelle Bachelet's first commitments during her presidency was to create a social protection system for early childhood. This aimed to ensure equal opportunities for all children, thus assuring their right to develop as a way of enabling the socioeconomic development of the country. In 2006, a Presidential Resolution created a technical advisory committee. Three months of work, with the participation of stakeholders from different sectors (representing ministries and technical experts), resulted in the development of *The Future of Children is Always Today*. This document represents the foundation for the design of the national child protection system known as *Chile Crece Contigo* (Chile Grows With You, CGWY). The Ministry of Planning and Cooperation was designed to coordinate all the ministries involved in this process (health, education, finance, culture, justice, labour, housing and women).

Key point of departure: One image, one budget with many actors and sectors working together. Based on a comprehensive set of health social services (Fig. 6.2), CGWY was implemented at municipal level ensuring universal care for pregnant women and children aged from 0 to 4 years (represents almost 80% of the population covered by the public sector). Each municipality created a local team to coordinate the interventions. In the health sector, a manager was responsible for follow-up in terms of coverage and quality. Culture and contextual adaptation of policies demands the understanding that this environment was conditioned by the personal history and commitment of President Bachelet who opened a window of opportunity which made ECDs a high priority in the policy agenda.

Social services provided by CGWY

Services for *all* Chilean children aged 0 to 4 years (100%)

1. Educational programmes for each citizen
2. Information available through the Internet
3. Legislative improvements to protect maternal and paternal rights

Services for children and their families using public health services (80% of the population)

4. Psychosocial support programme – a longitudinal intervention (ECD promotion, parenting education and support, maternal depression screening and treatment)

Case study 6.2 *contd*

Services for vulnerable children and their families (60% of children using public health services)

5. Home visits by primary care team using an integrated approach
6. Cash transfers
7. Free childcare of accredited quality
8. Priority access to public services (housing, employment, special programmes for single mothers and others)
9. Support for children with disabilities
10. Special support for adolescent parents.

Implementation started in 100 municipalities in 2007 and was scaled up to 345 municipalities in 2008. The challenge of rapidly implementing a comprehensive policy included designing a working plan, setting local networks and well-defined communication routes. The Ministry of Planning and Cooperation performed an effective coordinating role using a participatory methodology based on the annual definition of the priorities for each sector, implementation activities, an evaluation model and sectoral budgets. Some centralized activities were defined in order to optimize resources and reduce bureaucratic processes at local level. Periodic intersectoral meetings with policy-makers' participation were held at national level, and at regional and local levels. The objective of these meetings was to analyse the implementation process, identify barriers and needs to be met and a continuous quality improvement process. An information system was implemented to allow responses to alarms and monitoring of different interventions and the services' performance. Political will was a key issue in the implementation and sustainability of CGWY. In the context of new elections there was a risk that the policy would be discontinued, therefore a law was passed to ensure future sustainability (September 2009).

6.3 The need for a socially accountable approach to ECD-HiAP

Today, there is overall consensus that development is not limited to the growth of the gross national product. The UNDP articulates sustainable human development as "expanding the choices for all people in society" (18). The Office of the High Commissioner for Human Rights (19) recognizes it as an approach that "links poverty reduction to questions of obligation, rather than welfare or charity". Additionally, the promotion and defence of human rights

have become increasingly important values. A large majority of countries have signed a number of international human rights treaties that hold certain levels of authority over national practices and international relations.

Their impact on the lives of people is the most relevant issue in monitoring the state of these human rights treaties within countries. The regulatory bodies for these treaties are interested in not only the actions taken but also, more importantly, the impact of these actions on the rights holders. Action and its evaluation go hand in hand. The CSDH final report includes impact evaluation and understanding the effects of our actions as one of the three overarching recommendations for improving health and reducing health inequities of populations (20, see also Chapter 4).

Generally, the obligation to defend/promote human rights treaties passes to countries upon ratification. Governments have a duty to do all they can to realize these rights but, because resources are scarce and barriers considerable, some require progressive realization over time, rather than immediately. It is not always possible to fulfil all rights all the time and difficult choices need to be made at many points to achieve sustained progress. Nevertheless, there is an overall obligation to move toward the fulfilment of all rights in the medium to long term and therefore ways must be found to monitor progressive realization for accountability. Information is one of the fundamental elements of accountability. Accountable governments proactively declare and justify their plans of action and results and are sanctioned accordingly, both positively and negatively (21). Creation of information, ongoing data collection and infrastructures to collect this data are a core necessity.

Improving developmental outcomes in the early years is a strategic and cost-effective entry point for governments to enhance children's health and reduce population health inequities over time. Convincing evidence indicates that improving ECD through effective policies and programmes can set the child on a healthy life-course trajectory (10). Hence, governments should not only invest strategically in ECD but also monitor the impact of these investments by evaluating the effectiveness of their actions on children's (and ultimately on societies') health and development.

Therefore, governments that want to make significant progress in ECD first require a comprehensive system of accountability that closely monitors the actions and their outcomes on children. Such a comprehensive system would have two tiers. The first would take a rights-based approach to ECD, having the ability to monitor existing capacities (e.g. policies, programmes) designed to fulfil children's rights as articulated in the CRC. The second tier would monitor and measure the impact of fulfilment of children's rights on the developmental outcomes of children over time.

The CRC is the most widely sanctioned international human rights treaty, having been ratified by 193 countries. Ratification obliges countries to submit periodic reports to the United Nations Committee on the Rights of the Child (UNCRC). Securing the rights articulated in this convention is seen as a potentially effective approach for improving the quality of early experiences. A robust child-rights monitoring system is an important foundation for securing rights and thus improving the lives of the world's children.

Monitoring is essential to fulfilment of the rights articulated in the CRC. In 2002, the UNCRC came to an alarming realization that these reports often overlooked very young children (0–8 years) and focused mostly on older children. This was resolved by producing a resource document for implementing child rights in early years; in recent years, this has been operationalized as a series of comprehensive and easy-to-follow indicators (22, 23). The experience of (successfully) piloting these indicators in the United Republic of Tanzania and Chile revealed that, while the technical aspect of such monitoring represents an opportunity for a thorough inventory of the country's capacities for implementing child rights, the human aspect provides a chance to improve inter- and intra-ministerial communication. Thus, it also engages some vital players who are traditionally under-represented in the process of realizing the CRC (see Case study 6.3).

The second tier of a comprehensive system of accountability to young children should focus on monitoring the state of development across the whole population of children. Such surveillance facilitates detection of modifiable differences over place and time and can point societies towards the factors (both programmatic and societal) that are most effective in enhancing developmental outcomes for children. The Early Development Instrument (EDI) is one of the most prevalent indicators for monitoring the state of ECD (26). This population-level tool measures developmental changes or trends in populations of children. Early childhood coalitions, ECD workers and school representatives can use EDI data to inform their work with children and young families by identifying strengths and needs within their communities. Additionally, politicians and policy-makers can use EDI data to plan ECD investment, policy and programme development (see Case study 6.4).

These two-tier enhanced and proactive monitoring systems (i.e. side-by-side monitoring of CRC and ECD) can provide valid, comprehensive information for national and international policy-makers and decision-makers, and for civil society actors. Based on the experience of monitoring child rights in the United Republic of Tanzania and Chile, it is believed that implementation of a comprehensive monitoring system would be a powerful impetus to raise critical queries, encourage dialogue and motivate action.

Case study 6.3 *Implementing GC7 indicators in low- and middle-income countries*

The CRC was presented to the world in 1989. Ratified by 193 countries to date, this obliges countries to submit periodic reports to the UNCRC. By 2005, it was clear that many countries were not reporting consistently on young children (0–8 years). In response, the United Nations issued *General Comment No. 7: Implementing Child Rights in Early Childhood* (GC7), outlining how the CRC should be interpreted for children between the ages of 0 and 8 years. GC7 explicitly recognizes that children in their early years are clearly "holders of all rights enshrined in the Convention." Also, that "early childhood is a critical period for the realization of these rights" (24).

In 2006, UNCRC invited the Human Early Learning Partnership (HELP) in Canada to act as secretariat for an ad hoc group of international agencies developing an indicator framework to operationalize GC7. The GC7 Indicators Group developed a series of indicators and presented this framework to the UNCRC in 2008. The first pilot test of the indicators was completed in the United Republic of Tanzania (2010) and Chile (2011). Piloting was successful in both countries, showing that both low- and middle-income countries had the capacity to: create intersectoral task forces to implement the indicator framework; conduct a national self-study of policies, programmes and outcomes in early childhood, working part-time over several months; and access and collate relevant documentation to produce a comprehensive understanding of the state of child rights in early childhood.

After two years under construction, HELP launched the electronic version of the tool on 20 November 2012 (25).

Case study 6.4 *Measuring the state of ECD at population level in Canada and Australia*

The EDI measures ECD in five broad domains of human development: physical well-being; social competence; emotional maturity; language and cognitive development; and communication skills and general knowledge.

Finalized in Ontario in 2000, the EDI has since become a population-level research tool utilized to varying degrees in all Canadian provinces and territories. By the end of 2013, Ontario, Manitoba, British Columbia, Saskatchewan, Alberta, Prince Edward Island, New Brunswick, Yukon, Northwest Territories and Quebec will have completed full population level implementation; Nova Scotia, Newfoundland and Nunavut will have partial

Case study 6.4 *contd*
coverage. In certain regions, most notably British Columbia, the EDI has been completed on multiple successive cohorts thereby allowing tracking of changes in the state of ECD.

Internationally, there is growing evidence of the EDI's validity in different countries, allowing cross-country comparisons. A small sample of EDI questions has been adapted for use in UNICEF's Multiple Indicator Cluster Survey, a periodic random sample survey in 43 poor and middle-income countries. Thus, the EDI is emerging as the basic referent for international ECD comparisons. Societies with population-based EDI data already have the core outcome data required to fulfil their commitments under the CRC.

In 2009, the EDI was completed on 97% of all kindergarten-aged children in Australia. It has now been implemented in regions of different sizes in over a dozen countries outside Canada and Australia.

In summary, ongoing monitoring of the fulfilment of rights in early childhood (using the indicator framework) combined with population-based monitoring of ECD outcomes (using the EDI or the Multiple Indicator Cluster Survey) are a new foundation for policies and programmes leading to measurable improvements in ECD outcomes over time. In practice, such a high-quality population-based monitoring system can motivate substantial new investment in ECD, thereby enhancing health status and the state of development of nations.

6.4 Conclusions

> "*Many of the things we need can wait. The child cannot.*
> *Right now is the time his bones are being formed,*
> *his blood is being made, and his senses are being developed.*
> *To him we cannot answer 'Tomorrow', his name is today*"
>
> Gabriela Mistral (May, 1948)

The neurosciences, economics, sociology, health, education, urbanization and other disciplines show enough evidence on the importance of ECD for social development and well-being. By promoting ECD-HiAP, and investing in ECD programmes, governments have the opportunity to break the cycle of inequities that has dominated the lives of millions of children and families at the global level, but mostly in low-income and middle-income countries. Traditionally, in public health, it is common to talk about 'the burden of disease' as a measure of the impact of health problems at population level. We would like to introduce

the concept of 'burden of responsibility', recognizing the critical role played by politicians and policy-makers in terms of ensuring every child's right to healthy development. In other words: to promote better societies. No single policy or strategy can lead to a reduction of health inequalities and level socioeconomic gradients in health. A coordinated and multifaceted approach is required, comprising policies and interventions across a range of the most relevant entry points.

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*Clyde Hertzman: celebrating his legacy

Dr Hertzman, trained as an MD, was the voice of social justice for children across many regions of the globe. He understood the significance of early childhood development and population health and the idea that conditions should not be studied in isolation but within the context of a broad spectrum of social and economic determinants. Passionate, relentless in the pursuit of truth, an endlessly energetic leader and possessor of a brilliant insightful mind, Dr Hertzman dramatically altered the way that Canada and, increasingly, the world thinks about the importance of early childhood. In 2010, Clyde was the recipient of the Canadian Institutes of Health Research (CIHR) award for Canada's Health Researcher of the Year. He was inducted as an Officer of the Order of Canada in 2012, just a few months before his untimely departure. These words are meant as a heartfelt tribute from the co-authors of this chapter to a great leader, a caring friend and a unique thinker; and his legacy.

Chapter 7

Work, health and employment

Jorma Rantanen, Joan Benach, Carles Muntaner, Tsuyoshi Kawakami, Rokho Kim

Key messages

- Over 3 billion working people in the world spend one third of their adult life at work. Work is an important determinant of their health: with potential enhancement of health and work ability in good jobs and adverse effects in poor working conditions. Conditions of employment vary widely between and within countries and between different groups of workers, with great inequities among working people.
- The estimated total human loss from occupational accidents and work-related diseases is 2.3 million deaths annually, as well as manifold losses of work ability and lost job opportunities. Occupational hazards lead to economic loss of 4–6% of GDP, corresponding to more than one half of a country's typical health budget. Evidence from the best performers suggests practical possibilities to reduce such losses substantially and thus improve health, work ability and the productivity of working populations.
- Effective internationally approved policies and instruments (e.g. ILO conventions and recommendations) are available for national-level development of working conditions with decent employment; gender equality; basic rights at work; social protection and social dialogue; and good practices for occupational safety and health (OSH) and occupational health services (OHS) for all workers. Ratification and implementation of such instruments by all countries would be the most effective way to alleviate the major inequities in the global world of work.

- Government leadership, in collaboration with social partners, is necessary for the design and implementation of national policies, strategies, programmes and systems for improving conditions of employment, safety and health, OHS, social protection and basic rights at work. Combination of vertical sector-specific and horizontal intersectoral policies is encouraged.
- Government and public-sector interventions and services are critical for support of services and good practices for better inclusion and formalization of small enterprises, self-employed people and other less organized and underserved sectors, including vulnerable groups.
- To alleviate major inequities, the 200 million unemployed people and 1.6 billion vulnerable workers need special actions for decent work, safety and health through inclusive and gender-sensitive employment policies, strategies and programmes. Better integration into formal work life prevents the risk of exclusion.

7.1 Introduction

Work, workplace and employment conditions are crucial for the health and livelihood of individuals, their families and society as a whole. Work is a critical asset for society in terms of maintaining social fabric; providing resources for societal functions; and sustaining institutions, infrastructures and community services, including training, education and health care. Participation in work life enables individuals and their families to be economically independent, develop their working skills and open social contacts (1).

Working people spend one third of their time at work and the conditions in which people work have important effects on their health. Good conditions of work are known to promote health, work ability and long careers and to support sustainable economic development. Workplaces with poor conditions are hazardous (possibly even fatal to health) and show low productivity. Global epidemics of occupational accidents and diseases, work stress, and work-related musculoskeletal, cardiovascular, respiratory and psychological disorders affect the health, safety and work ability of working people and result in over 2 million fatalities per year. Conditions of employment, job demands, workloads, physical, chemical and biological hazards and risks at work, and the psychosocial quality of work communities vary widely between and within countries (2–5).

With an estimated 350 000 fatal occupational injuries each year, and almost 2 million deaths from work-related diseases, the total number of work-related deaths is comparable to the numbers of victims of major global epidemics such as malaria, tuberculosis and HIV/AIDS (Table 7.1). In industrialized countries

Table 7.1 *Facts on the global world of work*

Dimension	Data	Trend	Source
Workers			
Workers of the world	3.2 billion (economically active)	+	ILO 2012[2]
New workers	42 million per year	LDCs +, DECs -	ILO 2012[2]
Unemployed	200 million	+	ILO 2012[2]
Young unemployed	75 million	+	ILO 2012[2]
Vulnerable workers	1.52 billion	+	ILO 2011[4]
Working poor < US$ 2 per day with families	900 million	Total number stable, rate declining	ILO 2012[2]
Domestic workers	100 million	Stable	ILO 2010[8,9]
Migrant workers	105 million	Temporarily -, Long-term +	ILO 2010[8]
Indigenous people	350 million in 70 countries	-	ILO 2010[8,9]
Informal economy workers	1 billion	+	ILO 2011[4], ILO 2010[9]
Workers 65+ (economically active)	102.4 million (20% of 65+, males 28%, females 15%)	M - F +	UN DESA 2009[10], UNFPA 2012[11]
Workers with disabilities	785 million	Stable	ILO 2012[2], WHO & World Bank[12]
Mode of employment (ICSE-93, ILO 2012)			
Waged and salaried workers	1.440 billion (48%)	+	ILO KILM 2009[13]
Employers	75 million (2.5%)	-	ILO KILM 2009[13]
Own-account workers	990 million (33%)	+	ILO KILM 2009[13]
Contributing family workers	495 million (16.5%)	-	ILO KILM 2009[13]
Social protection			
Workers without old-age pension scheme	1.9 billion (60%)	-	ILO 2007[14], ILO 2010[8]
Workers without unemployment protection	68% of ILO member states. In Africa, Asia and Middle East less than 10% of unemployed	-	ILO 2012[2], ILO 2010[8]

Table 7.1 *contd*

Dimension	Data	Trend	Source
Social protection *contd*			
Workers without compensation for occupational injuries and diseases	1.92 billion (>60%)	+	ILO 2007[14], ILO 2010[8]
Occupational safety and health			
Workers without coverage of labour inspection/OSH inspection	2.4 billion (75% of workers worldwide)	+?	Rough estimate calculated from ILO 2005[15], ILO 2010[8], ILO 2011[4], ILO 2012[2]
Workers without OHS	2.7 billion (85% of workers worldwide)	+	Rantanen et al. 2012[16]
People without access to universal health-care services	2.1 billion (33% of population)	+	ILO 2007[14], ILO 2010[8],
Health poverty	100 million	+	ILO 2007[14]
Total number of injuries/fatalities by occupational accidents	317 million injuries, 321 000 fatalities	Stable	ILO 2011[3]
Occupational and work-related diseased (total)	160–200 million diseased	+	ILO 2011[3]
Fatal occupational diseases	2.02 million fatalities	(e.g. 100 000 asbestos deaths)	ILO 2011[3]
Social dialogue			
Collective bargaining coverage	In 111 countries (60% of countries) less than 20% of workers covered	-	ILO 2012[17]
Basic human rights at work			
Child labour	215 million	-	IPEC 2011[18], ILO 2010[8], ILO 2012[17]
Hazardous child labour	115 million	-	IPEC 2011[18], ILO 2012[17]
Forced labour	18.7–27 million	-	ILO 2012[17]
Forced sexual exploitation	4.5 million	?	ILO 2012[17]

Note: LDC – least developed country; DEC – developing country.

the economic loss from occupational risks currently amounts to 4–6% of GDP. Occupational accident rates between the least developed countries and advanced industrialized countries differ by three orders of magnitude. However, in advanced industrialized countries the risk of occupational injuries also varies by an order of magnitude between various sectors of the economy and between the lowest risk and highest risk occupations (4–7).

7.2 Workers, employment and workplaces

7.2.1 Workers and employment

The estimated total working population of the world is 3.2 billion, including 205 million unemployed. The working population comprises 76% of the total world working-age population and 47% of the total world population (2, 4, 11).

Table 7.2 *Distribution of employed people in different regions*

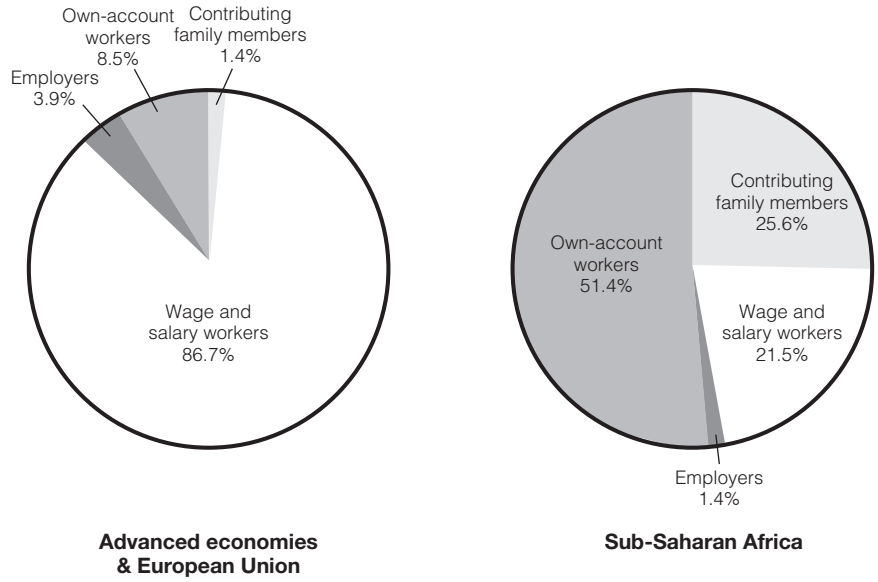
Region	Number employed (millions)	%
Developed economies[1] and EU	469.5	15.2
Central and south-eastern Europe and CIS[2,3]	163.9	5.3
East Asia	827.7	26.8
South-east Asia and Pacific	296.4	9.6
South Asia	626.0	20.3
Latin America and Caribbean	265.7	8.6
Middle East	62.8	2.1
North Africa	63.6	2.1
Sub-Saharan Africa	309.2	10.0
World total	**3084.8**	**100.0**

Source: ILO, 2012 (2); ILO, 2011(4). [1] Including Australia, Canada, Iceland, Japan, New Zealand, Norway, Republic of Korea, Singapore, Switzerland and United States. [2] Other non-EU European countries. [3] CIS: Commonwealth of Independent States.

Employment status varies widely in the global world of work. The ILO classifies four main (economic) categories for employment: (i) waged and salaried workers; (ii) employers; (iii) own-account workers; and (iv) contributing family members (2, 7–9). The majority (70–86%) of workers in industrialized countries are wage earners, usually on permanent contracts; the majority of workers in sub-Saharan Africa and south Asia are own-account workers or contributing family members and, in fact, informally employed (Fig. 7.1).

In general, the more informal the employment the higher the level of employment instability and job insecurity; the lower the status of the employee; and the higher the risk of unemployment and of economic and health and safety risks. Informality and instability are associated with low income, lack of social protection, low or non-existent access to health services and other forms

Fig. 7.1 *Forms of employment in advanced economies & EU and in sub-Saharan Africa*



Source: ILO, 2009 (13).

of vulnerability, including working poverty. The majority of workers of the world (70–80%) work in such informal, unstable conditions (see Table 7.1 and Fig. 7.1) (8–9, 13, 19–21).

Precarious workers (i.e. with employment contracts but for either fixed or very short time) are increasing in number. Informal workers without contracts with an employer, own-account workers (self-employed) and "nominally self-employed" are increasing. Several groups of workers are classified as vulnerable, with different types of criteria and in different contexts (Table 7.3). Two main categories of vulnerable workers can be identified (19–26).

1. *Economically and socially vulnerable*: own-account workers and unpaid family workers, unemployed workers, migrants and working poor, precarious workers and informal workers. Their protection needs actions from employment and social policies and greater coverage with OSH services (19, 23–26).
2. *Health vulnerable*: young workers, child workers, female workers, ageing workers, workers with chronic diseases, workers with learning difficulties, disabilities or special biomedical, physiological or psychological characteristics such as allergies. These groups' primary needs are health and safety interventions through OHS and through general health services (25–28).

Table 7.3 *Examples of vulnerable groups*

Group	Typical vulnerabilities	Global estimate & trend	Reference
Young workers 15–24	Short work experience, limitations to physical workload, elevated risk of accidents (males), youth discrimination High risk of unemployment (75 million)	617 million Trend: developed economies – developing countries +	ILO 2011[4]
Female workers	Double workload Reproductive health Low pay, unpaid work, working poverty Precarious, part-time or informal status	1.28 billion (40% of global workforce) Trend +	ILO 2010[9] ILO 2012[28]
Aged workers 65+	High occurrence of chronic disease Physical working capacity declines Limitations e.g. to shift work Risk of unemployment and age discrimination	102.5 million (20% of all 65+) Trend +	UN DESA 2009[10] UNFPA[11]
Child workers	Age 10–14 or <17. Physical, chemical, biological and psychological hazards Child work prevents participation in school	215 million Trend -	ILO 2012[17] IPEC 2011[18]
Migrant workers	Short work experience, language difficulties, cultural adjustment, health problems, accident risks	105 million Trend +	ILO 2010[8] ILO 2012[17]
Workers with impairments, chronic diseases and disability	Limitations in physical work ability Vulnerability to hazardous exposures and workloads Work and workplace not adjusted to workers' needs Lack of access to health care and assessment of health and work ability Lack of measures for maintenance and improvement of work ability	785 million (24% globally, 18.4% in the EU) Trend +	Dupré & Karjalainen 2003[26] ILO 2012[17] WHO & World Bank 2011[12]

Table 7.3 *contd*

Group	Typical vulnerabilities	Global estimate & trend	Reference
Unemployed	Longer unemployment increases risk of stress-related disorders, stress symptoms, psychological depression, elevated blood pressure and sleep disorders, increased mortality from cardiovascular disorders and possibly suicides; affects working skill, competence and economy of the worker and family	200 million Trend: short term + long term -	CPHA 1996[29] ILO 2011[2]
Working poor	Poverty increases numerous health problems, affects nutrition and work ability Poorest workers may not be able to pay for health services for themselves and family members	900 million Trend -	CPHA 1996[29] ILO 2011[4]

Female workers comprise 40% of the global workforce and employed population. Female participation in the labour market shows a growing global trend and traditionally is highest in the poorest regions; women comprise the majority of the services sector and agricultural workforces. Generally, women's work is classified as 'light' but some occupations (e.g. agricultural workers in developing countries; ageing cleaners in high-income countries) have high occurrence of physical overload. Monotonous work, psychological stress and a double burden of work (workplace and home) are typical for female workers everywhere. Women are over-represented among informal workers, domestic workers, contributing home workers and unpaid workers. This typically results in lack of social protection and low income. The majority (70%) of working poor and 60% of illiterate workers are female. Gender segregation shows that well-identified adverse effects (lower pay, exclusion from certain jobs, discrimination and sexual harassment) persist everywhere although the causes and forms vary between regions. Gender equality is best realized in the formal labour sectors in countries with highest incomes; the most striking inequalities and vulnerabilities occur in the developing regions (9, 19, 25, 28).

7.2.2 Workplaces and working conditions

The most advanced industrialized countries have shown 40–50% risk reductions in fatal occupational accidents and substantial reductions in the risk of occupational diseases during the past two decades. In spite of such success, the economic loss from occupational risks still amounts to 4–6% of GDPs, corresponding to at least one half of typical national health budgets (5–7).

The declining trend in adverse occupational health outcomes among the best performers is continuing, despite the low levels of risk already achieved. This shows that there is no lowest limit in risk reduction (zero risk policy). Such zero risk policies are typical for the best economic performers who understand how to use ambitious occupational safety and health policies for both protecting the health of workers and improving productivity through better safety and health at work. Successful implementation of such national policies, strategies and programmes in practice needs close collaboration between sectors, including labour, health, social security, education, industry, agriculture and finance (1–6, 30).

The risk of occupational injuries in advanced industrialized countries varies by one or two orders of magnitude between the lowest and highest risk occupations. The risk difference in contracting occupational disease is even wider. Highest risks are found in certain hazardous sectors such as mining, construction and agriculture, in small enterprises, among self-employed and informal workers, and, particularly, in developing and transitory countries (3). The vast majority

of the world's 1 billion agricultural workers are without any OHS services. The ILO has developed innovative low-cost methods to fill the gap in service coverage (see Case study 7.1) (31).

On average, there is much evidence that small enterprises are at higher risk than larger enterprises for all accidents, fatal accidents and other hazards in both the industrialized and the developing world (32–34). In the EU15, a total of 82% of all occupational injuries and about 90% of all fatal accidents are registered in small and medium-sized enterprises (SMEs). Lack of sufficient competence and capacity to assess risks and manage chemical hazards and ergonomic problems means that the risk of occupational and work-related diseases has

Case study 7.1 *Occupational safety and health (OSH) protection for grass-roots farmers in Viet Nam and the Philippines*

Agriculture accounts for 63% of the total workforce in Viet Nam and 36% in the Philippines. Both countries show a need to enhance awareness on safety and health among farmers. The Work Improvement in Neighbourhood Development (WIND) programme in Viet Nam has trained many volunteers to extend practical OSH information and methods to grass-roots farmers. The training covers areas such as materials handling, work posture, machine and electrical safety, working environments, control of hazardous chemicals, and welfare facilities. WIND farmer volunteers train their neighbours by demonstrating existing good local examples. The ILO/Japan Regional Programme for Capacity Building of Occupational Safety and Health (OSH) trained 480 WIND farmer volunteers in 14 selected Vietnamese provinces between 2004 and 2007.

In the Philippines, the Department of Agrarian Reform and Department of Labor and Employment are working together to provide WIND training to farmers. The Vietnamese and Philippine experiences with WIND have been shared with Cambodia, India, Lao People's Democratic Republic, Nepal, Republic of Korea, Sri Lanka and Thailand. Countries in central Asia, Latin America, Africa and eastern Europe have increasingly been applying the programme. Three factors contributed to the success of this approach: (i) well-designed and validated methodology for training trainers using a training-by-doing approach, group learning and peer-training strategies applied in villagers' own farms; (ii) interventions were low-cost solutions affordable for farmers; and (iii) involvement of volunteer villagers facilitated adjusting the methods to local conditions within a neighbourhood approach that generated trust and supported acceptance.

Source: Kawakami, That Kai, Kogi, 2012 (31).

also been shown to be higher in small and medium enterprises, even when under-reporting is assumed to be substantial. Conversely, closer interaction and social relations within small working units means that smaller enterprises are reported to have better psychosocial conditions of work. Small enterprises have become the only sector with increasing net employment and therefore virtually all advanced economies have given high priority to promoting their generation. It is important to integrate strong safety and health programmes within such development strategies – for example, by making decent work, safety and health a condition for public development support (33–38).

The globalization process leads big enterprises to merge, thereby growing larger and fewer. Although there are only 63 000 (0.04% of world total) large multinational enterprises worldwide, employing 86 million workers (0.27% of world total), they produce substantial amounts of their products through smaller subcontractors and control 70% of world trade. They have great opportunities for serving as models for decent work practices in their own and subcontractor settings. Simultaneously, new economic and enterprise structures are emerging, with a growing trend in numbers of micro, small and medium-sized enterprises and self-employment. About 90% of enterprises are small, employing fewer than 50 workers. The formal micro, small and medium-sized enterprises employ about one third of the world workforce. Several types of subcontracting and other partnership relations and networks are formed between the SMEs and big companies. The majority of workers in developing countries work in small enterprises or are self-employed in the agriculture, domestic work and informal sectors (33–38). Together with ASEAN governments, the ILO has successfully experimented with a new approach – Work Improvement for Safe Home (WISH) – for practical actions for improvement of working conditions for home workers and the informal sector (see Case study 7.2) (39).

A new global trend detaching the financial sector from the real economy has resulted in a continuing financial crisis. Severe injuries to economies have had a dramatic impact on workers' situation through constriction of the labour market, loss of jobs, growing unemployment and lower quality jobs. In turn, these have exacerbated longstanding problems related to poverty and are widening inequality among working people, particularly young and vulnerable workers. Devaluation of human work has become a global trend, with a tendency to lower salaries and social protection, and international organizations and national governments struggle for crisis management with only modest success (40). Long-term predictions based on experience from past financial crises point to increasing insecurity and unemployment associated with health problems such as elevated total morbidity and mortality in cardiovascular and mental health disorders (depression, suicides) among working populations. These are likely

Case study 7.2 *Participatory approaches to improving safety, health and working conditions in informal economy workplaces in south-east Asia*

Throughout Asia, 60% of the workforce is informal, lacking access to formal safety and health services. Hence, the Association of Southeast Asian Nations (ASEAN) faces an increasingly important challenge to provide adequate OSH protection to informal economy workplaces such as homes, small construction sites and rural farms. Informal-economy workers are often exposed to chemical, physical and ergonomic workplace hazards without being aware of the health risks. Such workplaces often lie outside the scope of OSH legislative frameworks, making it difficult for government inspectors to reach them. In addition, accidents and diseases are seldom reported to the government. Participatory training programmes to improve OSH have provided practical means to address these issues, and are increasingly applied in informal enterprises.

WISH is a typical participatory training programme. Designed for home workers and small businesses, WISH training encourages participating home workers to apply an action checklist with illustrated "good examples", learn to recognize OSH risks at work and to seek low-cost, quick solutions. Wherever possible, local good practices are presented as workable solutions. The WISH programme focuses on five technical areas: (i) materials handling; (ii) workstations; (iii) physical environment; (iv) machine and electrical safety; and (v) welfare facilities. Improvements in these technical areas contribute substantially to safety, health and productivity. Participatory training programmes have been incorporated into national OSH programmes and policies. With technical cooperation from the ILO's Informal Economy, Poverty and Employment project, government inspectors in Cambodia have worked collaboratively with local trade unions, employers' organizations and NGOs to train their representatives as participatory OSH trainers. Through local networks, trainers frequently visit home workplaces, small construction sites and small farms to provide on-site OSH training. Rural villages, some without electricity, have participated in this practical OSH training and subsequently implemented improvements in safety, health and productivity. With national support and strengthened networks, these practical programmes are gradually expanding their reach into more informal-economy workplaces. Success factors for these concrete work environment interventions to fill the implementation gap among underserved and vulnerable workers include the: (i) availability of ILO technical assistance; (ii) ILO staff's long experience of developing methods for participatory training; and (iii) target constituents' interest in participating.

Source: International Labour Office Regional Office for Asia and the Pacific, 2007 (39).

to be seen for several years, possibly up to a decade (29). Actions for better international and national governance and regulation of financial sectors; more accountable and transparent financial practices; fair distribution of financial risks to their creators; and better protection of workers and vulnerable people in times of crisis are proposed as ways to tackle the crisis (29, 40–42). In times of crisis, there is a risk of compromising the quality of employment, safety and health. Most occupational fatalities occur in developing countries and countries in transition, where capacities for control and management of risks are less developed. The working populations of the least developed countries and advanced industrialized countries show a difference of three orders of magnitude for occupational accident risk.

The current estimate suggests that there are 1.6 billion informal-economy workers comprising 50–60% of the world workforce. Precise numbers are not available due to the special dynamics of 'informalization', poor monitoring, lack of registration and statistics and the fact that some informal work is illegal in many countries. Protection for these highly vulnerable workers requires action from the employment sector and social policies for 'formalization', i.e. registration and full coverage by labour, safety and health legislation, social protection, and OHS services (4, 19, 21, 22).

7.3 Policies for labour, occupational safety and health

Historically, workforce polices conducive to health have been developed at country level, especially in response to rapid industrialization in the nineteeth and twentieth centuries. In the globalizing world of work, the roles of intergovernmental and supranational political and policy actors have grown in the past few years and continue to do so. The universal right to health and safety at work and decent conditions of work have been unanimously endorsed by governments in several high-level United Nations forums – the General Assembly; Committee on Economic, Social and Cultural Rights; ILO; WHO – and in the EU. Universal consensus holds that in principle such rights belong equally to every working individual including workers in the formal employment, private and public sectors; in large, small, medium and micro-enterprises; among self-employed, informal and domestic workers and permanent, casual and precarious workers. The ILO is a global guardian of human rights and social rights at work; similarly, WHO is a global guardian for the right to both health in general and health at work (42–49).

In the past 20 years, national governments' policy space for work-life developments has constricted and dependency on global factors has grown (see Chapter 5). While recognizing numerous positive opportunities and effects of

globalization, The World Commission on the Social Dimension of Globalization concluded that the main direction of the process is too heavily dominated by the economic dimension. Steered by the strongest global economic and political forces, developing countries are largely excluded from positive impacts and the legitimate needs and rights of the weakest and vulnerable majority of people are ignored. The Commission proposed numerous global level actions for "turning commitment to action" including improvement of global governance; more focus on people; greater solidarity; better accountability; and effective, equitable markets (47). At national level, good political and democratic governance, an effective state, vibrant civil society and strong social partners with fruitful social dialogue were deemed important for strengthening governance of the effects of globalization (49).

7.3.1 ILO policy

ILO is the only tripartite United Nations agency that brings together representatives of governments, employers and workers from 185 countries to jointly shape policies and programmes promoting decent work for all. ILO conducts three main activities: (i) provision of international standards (conventions); (ii) training of governments, employers, workers and practitioners in member countries; and (iii) dissemination of practical information, exchange of experiences and facilitation of technical cooperation activities, particularly for low-income countries.

> *The 189 ILO conventions include eight 'core' conventions for protection of human rights at work; four 'governance' conventions for employment policy, labour inspection and social dialogue; and 177 'technical' conventions covering a wide range of aspects of work, including OSH (No. 155), OHS (No.161) and the promotional framework for OSH (No. 187). The three latter instruments aim at universal coverage of OSH and OHS for every worker and workplace (50).*

In 1999, the ILO launched the Decent Work Agenda (DWA) for the development of conditions of work globally. The DWA model integrates the policies and practices of employment, social security, health and safety, equity and human rights and social partners, through four pillars: (i) productive employment; (ii) social protection; (iii) social dialogue; and (iv) basic rights at work (51–53).

The DWA has been endorsed and supported by several other international bodies, including the United Nations, UNDP, Food and Agriculture Organization of the United Nations, EU, OECD and the G20. The ultimate objective is to ensure decent conditions of work, employability and good work ability for

every working individual and, through productive work life, to conduct long working careers and a decent life without risk of ill-health, poverty, exclusion or discrimination. The DWA has been found to have positive economic impacts at national and enterprise levels (40, 42).

The ILO developed a multiple set of indicators to measure DWA performance in countries. This includes employment opportunities; adequate earnings; decent working hours; combination of work and family life; work that should be abolished (child work); stability and security of work; equal opportunity and treatment and safe working environment; social security; social dialogue; and economic and social context for decent work. Currently, 116 national DWA programmes are ongoing or have been prepared, mostly in developing and transitory countries but in some advanced economies too (52–54).

7.3.2 WHO policy

WHO has recognized employment and work as one of the central social determinants of health and designed global health policies accordingly (54). Safe and healthy working conditions are included as health rights in the WHO Constitution (see Box 2.1)(46). In 1996, the WHA endorsed the WHO Global Strategy on Occupational Health for All. This emphasized occupational health policies; infrastructures, information systems and awareness of the needs for occupational health activities; OHS for all working people; and the necessary support services and human resources needed for implementation of the new strategy (1).

In 2007, re-emphasizing implementation of the WHO Global Strategy on Occupational Health for All, the WHA endorsed the WHO Global Plan of Action on Workers' Health 2008–2017. Its main objectives are to: strengthen the governance of national health systems in view of the health needs of working populations; establish basic levels of health protection at all workplaces and ensure that all workers have access to preventive health services linking occupational health to primary health care; improve the knowledge base on occupational health and stimulate incorporation of occupational health into other policies (55). WHO regional offices have produced regional strategies for occupational health and implement the Global Plan of Action at regional and country levels. These regional actions, and those of WHO headquarters, are supported by the global and regional networks of WHO Collaborating Centres in Occupational Health.

In 2003, the Joint ILO/WHO Committee on Occupational Health proposed a new concept – basic occupational health services (BOHS) – for extending these services to 2.5 billion workers and their workplaces (56–60). WHO

also provides Member States with policy and technical support on several occupational health issues including guidance in combating the most severe occupational diseases such as asbestos-related disorders and silicosis; work stress; and health promotion and tobacco control in the workplace. The BOHS approach has been piloted in several countries, including large pilot projects by the Ministry of Health of the People's Republic of China. It was found to be feasible for implementation for the largest workforce of the world (see Case study 7.3).

Case study 7.3 *Pilot projects for basic OHS in China*

With a workforce of 700 million, China faces occupational health and safety problems in both traditional industries and rapidly growing new economies. Fast growth in the numbers of small-scale enterprises and high mobility of working people (over 140 million internal workers migrated from rural north and west to south and south-east) add to the need to expand coverage and strengthen the capacity of OHS. Legislation on occupational health has been actively renewed but low (10–30%) coverage of OHS makes wide-scale implementation a major challenge. The State Council of China has adopted the National Occupational Disease Control Programme (2009–2015). This has ambitious objectives to extend OHS coverage, monitor hazardous exposures in 70% of workplaces, monitor health of 60% of workers in hazardous jobs, provide 90% coverage of accident insurance for formal workers and stepwise expansion of BOHS coverage. Since 2006, the Ministry of Health has organized pilot projects to study the feasibility and mechanisms for implementing BOHS initially in 19 counties in 10 provinces. The objectives were to explore various models for OHS provision; develop mechanisms for resource allocation and multisectoral collaboration; ensure workers' participation and expand OHS coverage with the help of the OHS network; provide universal sustainable access to OHS; and introduce appropriate and feasible technologies for service provision.

The programme was developed in three steps.

1. Organizing central governance and capacities in the Ministry of Health and the Center for Disease Control (CDC China) and carrying out a national survey of the OHS situation.
2. Building human resources with training; providing facilities and material capacities for OHS teams; and surveying local OHS situations, including drawing up county OHS profiles.
3. Developing, implementing and evaluating results of county BOHS plan.

Case study 7.3 *contd*

Evaluation of pilot projects showed positive results:

– local governments, enterprises and the public showed greater awareness of occupational health laws and occupational health needs;

– OHS capacities were substantially strengthened, competent BOHS teams and facilities were developed at county and township levels;

– coverage and content of OHS were substantially improved among small-scale enterprises and particularly among the underserved migrant workers, health examination rates increased from 68% to 90% in the pilot period and increased numbers of occupational diseases were identified;

– occupational health inspection and surveillance systems and expert networks were established.

In the second stage, the Ministry of Health decided to expand the BOHS pilot projects to cover 65 counties in 29 provinces.

Success factors included active support from the WHO Country Office in China and the commitment of the Ministry of Health and a number of other institutions, including good collaboration with the ILO Country Office for China and Mongolia. Systematic planning and evaluation of projects and implementation by local health centres facilitated implementation.

Source: Chen, 2010 (58).

7.4 National level policies and systems – the need for infrastructures, collaboration and social dialogue

At national level, practical implementation of decent work still needs much effort. Successful implementation and closure of the implementation gap in practice requires close collaboration between the administrative sectors, including labour, health, social security, education, industry, agriculture and finance. The best performers have generated sustainable solutions through a systems approach building up and strengthening (at all levels) structures for governance, enforcement and implementation, services, training, information and education, as well as social dialogue.

Governments in many (but not all) advanced economies have organized OHS for the majority, or at least half, of their workers. Some developing countries such as Thailand, Viet Nam and China have been able to show that grass-roots level occupational health and safety services can be organized cost effectively for previously underserved and high-risk groups (57–58).

Table 7.4 *Guidance for national system for employment, decent work and OHS*

System element	Reference
National policy, strategy, profile and programme documented and endorsed at highest level	
National DWA with four pillars: employment, dialogue, rights, protection	ILO guide for national employment policies [60]
	ILO decent work country programme guidebook and indicators [52, 53]
National OHS programme	C 155, 187
National OHS programme (separately or in combination with OSH)	C 161, 187
Enforcement and inspection	C 81, 129
Competent authorities	C 81, 155
Labour inspection	C 81, 155, 187
OSH inspection	C 155, 161
OHS inspection	C 161
Social dialogue and horizontal collaboration	
Collective bargaining system	C 98
National tripartite advisory and coordination committee	C 155
Tripartite drafting of laws, regulations, strategies and programmes, follow-up and evaluation	C 144, 151, 152
Forums and contacts with NGOs, civil society and interest groups	ILO Constitution Art. 3 [45]
Services and infrastructures	
Employment services	C 88, 122, 158
OSH services	C 155
OHS services, medical, hygienic, psychological, ergonomics etc.	C 161
Consultation (external) services	C 161, R 171
Secondary and tertiary level support services (e.g. measurement & analysis)	C 155, 161
Information systems and statistics	
Workforce and employment statistics	C 63, 160
Notification and registration enterprises	Business registration [60, 61]
Notification and registration of occupational accidents and diseases	CoP Notification and Registration
Awareness raising and media	C 187
Information services for authorities, employers, workers, experts and public	C 155, 161, 187 National CIS Centre [62]
Codes of practice and guidelines	ILO CoPs [63]
Training and education	
Authorities, inspectors, government officials	C 187
Employers	C 187
Workers	C 187
Experts and service providers	C 187
Research support	
National institutes	C 187
Universities	C 187

Note: C: Convention; R: Recommendation; CoP: Code of Practice. See ILO web site (50) for full texts of all ILO conventions and recommendations; ILO web site (63) for full texts of codes of practice.

A list of prerequisites critical for effective implementation at national level is presented in Table 7.4, with reference to the relevant international instruments and guidance. Virtually all of the instruments have been collectively approved by governments in the International Labour Conference, so lack of political commitment should not be an obstacle to implementation. The value of consistent policies and available infrastructures cannot be overestimated. If publicized effectively, decent work's positive impact on national and enterprise economies, and on rates of accidents and diseases, may help to generate national consensus (6, 7, 12, 20, 30, 56, 59).

In order to ensure participatory democracy, the involvement of NGOs, community interest groups and other voluntary organizations of workers should also be encouraged. Government should support the creation of precarious and informal workers' organizations based on relevant shared features, such as occupation (e.g. domestic workers, taxi drivers); workplace location (farmers markets, streets); and condition (e.g. migrant worker, production chains such as food industry chain comprising small-scale agricultural farmers to international trade corporations). Such organizations (e.g. trade unions) will strengthen the position of precarious and informal workers and make their interests and needs politically visible.

Underserved sectors and vulnerable workers will gain improved employment, safety and health situations and social protection through strong and systems-wide government and public sector decent work interventions covering all the relevant jurisdictions such as labour, health, training and education, social security, industry and agriculture. Access to good employment is a critical prerequisite for decent, safe and healthy work. Economic development policies and programmes should be promoted most in middle- and low-income countries, aiming at full employment in formal contracts with adequate remuneration and social protection and assuring social sustainability and unemployment reduction.

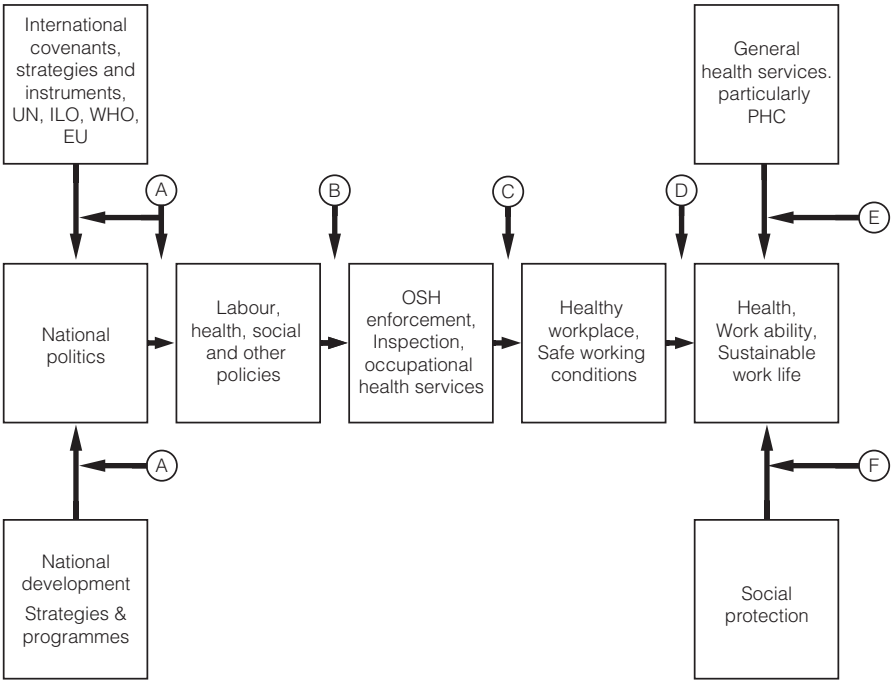
Good health is, and remains, a critical prerequisite for work ability and employability but few workers of the world have access to primary health-care services (30%) and to OHS (15%). Hence, it is proposed that the BOHS approach should be integrated with primary health-care units which also could support collaboration between health sector and decent work programmes (14, 16, 54, 64).

7.5 Implementation: policy interventions and entry points

Policy implementation is a chain process with several entry points, as illustrated in Fig. 7.2. Policy-makers can utilize such entry points as opportunities arise, as

they ultimately work towards reaching the objective of decent work and decent life (i.e. sustainable health, work ability and work life for workers). Most of the actions discussed below need active multisectoral and tripartite collaboration and contribution.

Fig. 7.2 *Entry points for multisectoral policy and practical interventions for work and health*



7.5.1 Entry point A: implementation of international strategies and instruments

Countries often face difficulties in the ratification and implementation of international covenants and instruments, despite their often unanimous adoption in the international forums. Globally, ILO conventions have had modest ratification rates: collectively only about 20% of the theoretical maximum, with a few important exceptions (65, 66). This drove ILO to undertake special actions for ratification of the most important core conventions, now ratified by over 160 countries (86%). The rates are poorer in specific areas such as OSH: collectively, the three key OSH conventions (No. 155, No. 161, No.187) have been ratified by 20% of countries. Some countries have successfully ratified the conventions but have been unable to implement them: approximately one fifth of the countries, as reported by ILO (50, 66). However, there have been some cases where countries have not achieved successful ratification but have applied conventions in policies and

as legal guidance, and have implemented them in practice. Available research evidence on the positive impact of ratification on accident risks shows a significant association between high ratification rates of OSH conventions and low risk of fatal accidents (59). Potential actions to overcome difficulties in the implementation of international strategies include incorporating objectives for decent work, safety and health into national development strategies and programmes. These include objectives for ratification and implementation of international agreements and strategies; provision of information to advise national policy-makers designing intersectoral approaches for decent work, and to generate United Nations/ILO mechanisms for international legal and financial sanctions to enforce protection of workers' rights.

7.5.2 Entry point B: integration and coordination of policies relevant to work and health

Many countries have intersectoral barriers which make productive and systematic collaboration between various jurisdictions problematic. This has been one of the main obstacles in effective implementation of international strategies and instruments. Labour and social policies are closely interdependent in the development of good jobs which ensure health, safety and social protection at work. Other sectors (e.g. education, industry, agriculture) may also offer relevant contributions. In some countries (such as China) and in the EU special high-level intersectoral councils, work life councils, OSH councils or other such mechanisms have been established as advisory bodies to government (or parliament) in order to enhance multisectoral approaches and collaboration. Countries such as the United Kingdom of Great Britain and Northern Ireland and Singapore have assigned financial resources and overarching implementation tasks for such bodies, either directly or through special agencies. Potential actions include the establishment of multisectoral advisory bodies to help policy-makers to coordinate efforts.

7.5.3 Entry point C: ensuring appropriate services, infrastructures and human resources for decent work

The role of labour and OSH inspections is to ensure the enforcement of employment and safety regulations. Inspectorates are available in most countries but almost universally suffer from shortages of resources, facilities and staff. Often, inspections do not cover small-scale enterprises, self-employed and informal economy workers, in spite of their high risks and often unfavourable working conditions. ILO Labour Inspection Convention (No. 81) provides guidance for minimum requirements for human resources for inspection. It is government's responsibility to fill the gap in coverage in order to comply with

the requirements of international standards and national law. The ILO's call for full coverage under the Labour Inspection Convention has supported the ratification policies in general. Convention No. 161 on Occupational Health Services has been ratified by 30 countries. Full coverage is also requested by the WHO Global Strategy on Occupational Health for All but still has not received a widespread response. Global coverage of OHS is as low as 15% of workers and the workers most in need do not have access to such services. Special efforts are needed to reach the underserved sectors and vulnerable groups. The ILO, WHO and the International Commission on Occupational Health (ICOH) have launched models for practical low-cost interventions for small enterprises, the self-employed and informal sector. These have been found feasible and effective at grass-roots levels (e.g. Work Improvement in Small Enterprises – WISE, WIND, BOHS). Potential channels for action are ratification of ILO core conventions, governance conventions and implementation of the WHO's Global Plan of Action (31, 39, 55, 56).

7.5.4 Entry point D: ensuring decent work at enterprise and workplace levels

The workplace is the ultimate site for ensuring safety and health at work. This happens best through collaboration between the employer and workers at the OSH committee, as required by ILO Occupational Safety and Health Convention (No. 155), Occupational Safety and Health Recommendation (No. 164), Occupational Health Services Convention (No. 161) and Occupational Health Services Recommendation (No. 171) (50). Globally, the majority of workers are employed by enterprises and in workplaces with limited or no resources for the provision of decent work, including health and safety. It is recommended that safety and health authorities provide public health interventions and OHS as external support for informal economies.

7.5.5 Entry point E: ensuring access to universal health services for all working people

The vast majority of working people (about 70%) and their families do not have access to comprehensive and competent health care. Poverty may prevent the use of services even when they are available. As health is an important prerequisite of work ability and thus of employability, every working individual and his/her family should be provided with adequate health services. The international experience speaks for a public universal health service, financed through public social insurance or from the public budget (14, 64).

7.5.6 Entry point F: organizing adequate social protection for all working people, including their dependants

The majority (at least 60%) of even formal workers and over 80–90% of the total global workforce live without adequate social protection such as insurance for health and disability; maternity benefits; pension; unemployment benefits; and insurance coverage for occupational accidents and diseases (14, 17, 64).

Potential channels for action for each entry point are outlined in Box 7.1.

Box 7.1 *Actions for each intervention entry point*

Entry point A: implementation of international strategies and instruments

Action 1. Generation of political support for ratification of international strategies through action of international coalition of global actors such as the ILO, other United Nations organizations and other international allies (OECD, G20, World Bank, IMF, WTO, EU) would help to transpose strategies into national law and further implementation. Potential channels for action: joint campaigns, technical training, information programmes and financing. Use of indicators, country profiles and transparent evaluation reports to ensure effective monitoring, auditing and follow-up of ratification and transposition processes would help to ground the political processes.

Action 2. Provision of information and advice to national politicians and policy-makers concerning design of intersectoral policies and strategies, as proposed by the ILO's DWA, with an emphasis on decent life dimension, equity, social protection and the positive economic impact of DWA.

Action 3. Generation of United Nations/ILO mechanisms for international legal and financial sanctions and corrective actions to combat severe violations of workers' basic rights, illegal employment practices and unreasonably hazardous working conditions. Trade agreements should be conditional on meeting criteria for decent work following the model of elimination of child labour in production of sports consumer goods.

Entry point B: integration and coordination of policies relevant to work and health

Action 1. Establishment of a multisectoral advisory body would help to coordinate the development of decent work life, health, safety and social protection at work that would involve all relevant jurisdictions and social partners. It would be advisable to include objectives for decent employment, safety and health, work ability, social protection, and training and education of employers and working people in governments' national development policies and plans. Respective bodies for intersectoral coordination and collaboration should also be established for the intermediate and workplace levels.

Box 7.1 *contd*

Entry point C: ensuring appropriate services, infrastructures and human resources for decent work

Action 1. Governments' ratification of the ILO core conventions on rights and employment and special conventions on OSH and OHS, and due implementation in collaboration with social partners, are recommended. This would help to ensure decent employment conditions through necessary national regulations, standards and infrastructures with sufficient human resources. Safety inspection and OHS should be extended to all workplaces and workers, including small-scale enterprises, self-employed and informal economy workers. Where appropriate, practical methodologies such as ILO's WISE, WIND and BOHS approaches should be used (31, 39, 56).

Action 2. Implementation of the WHO Global Plan of Action on Workers' Health 2008–2017 calling for organization of access to OHS for all working people including small-scale enterprises, self-employed and informal economy workers and other underserved and vulnerable groups (55).

Entry point D: ensuring decent work at enterprise and workplace levels

Action 1. ILO has developed the Decent Work Enterprise Index and manual for implementation of decent work at workplace level. Governments may benefit from ILO's technical and financial support in initiating national decent work programmes and from utilizing international advice in implementation of WISE, WIND and BOHS approaches (31, 56).

Action 2. Extension of adequate and well-functioning OHS to cover every workplace and all workers. Modern concept of occupational health targets advice and services on the prevention of occupational diseases and accidents, promotion of work ability, provision of outpatient services and rehabilitation. Other important targets are improvement of the work environment and development of work organization.

Action 3. In extending services to all workplaces, public sector interventions may be used to support and serve small-scale enterprises, self-employed and informal economy workers in their efforts to improve conditions of work, work environments and safety and health at work. This happens best in collaboration between the employer and workers within the OSH committee as required by ILO Recommendation No. 164 on Occupational Safety and Health and the Occupational Health Services Recommendation, No. 171 (50).

Entry point E: ensuring access to universal health services for all working people

Action 1. Improvement of primary health-care service coverage to reach every working individual and family, as recommended by WHO, including services for public and community health, and frontline prevention and curative services.

Box 7.1 *contd*

Action 2. Integration of the provision of OHS and BOHS into practice, particularly with primary health-care services. This will ensure availability of occupational health competence among service providers at primary health-care level (56).

Entry point F: organizing adequate social protection for all working people, including their dependants

Action 1. Development of social protection that is legislation-stipulated, adequate, fair, has full coverage and can be disseminated through public insurance policies. This should be produced as a joint effort by ministries of social security, labour and health in collaboration with social partners.

Action 2. Ensuring contributions to social security funding from employers, workers, entrepreneurs and self-employed people. In other words, formalization and registration of informal and unregistered economic operators, enterprises and workers to enable collection of contributions.

Action 3. Where contributions from uninsured workers are not possible (e.g. from working poor), funding of social protection should be organized on the principle of solidarity either from other contributors or from tax revenues.

7.6 Way forward – how to overcome the implementation gaps

Ratification of international instruments: a key action

Many countries stipulate workers' rights within their constitutions, either directly or as unenumerated rights, and in concordance with the UN rights instruments – the Universal Declaration of Human Rights; International Covenant on Economic, Social and Cultural Rights; and International Covenant on Civil and Political Rights (42–46). These provide basic principles of decent work for everyone, and have been ratified by more than 160 Member States. Yet, relevant and up-to-date strategies and instruments from international organizations are effectively implemented by only 20–25% of countries. Furthermore, the ratification rates of work environment conventions are relatively modest (66).

A study of 29 conventions – including all the instruments for labour administration and inspection, social protection and OSH adopted by the ILO Conference between 1975 and 1995 – showed a cumulated ratification rate of 13% (65, 66). Ratification rates were substantially lower among developing countries, with longer latency than in industrialized countries. Obstacles include a lack of political priority; shortages of administrative, financial and practical resources; and the anticipated need to draw up new legislation. In 1995 the ILO Governing Body sought to extend coverage of the eight most

important workers' right conventions by launching a campaign for their universal ratification. So far, an 86% ratification rate has been notified (66). Unfortunately, the list did not include OSH conventions (e.g. right to survive at work) despite over 2 million lives being lost annually through unsafe working conditions. As they have for the core conventions, the ILO could encourage and support governments in ratification of the international instruments for decent employment, social protection, OSH and OHS and social dialogue.

Implementation gap needs attention

Implementation of instruments is less probable without ratification, but can also fail after it. Positive trends are seen in some areas but the challenge of filling the implementation gap and of providing universal coverage of protection and services is still far from reality for the majority of workers and workplaces, particularly in the developing world. Transposing of international instruments through ratification into national law and practice should take place even more widely under the guidance and support of international organizations. The DWA paradigm provides an effective and feasible multidisciplinary and multisectoral framework and tools for such transposition and implementation (42, 52).

Globally, the majority of working people work in conditions which do not meet the ILO standards and lack adequate social protection, occupational safety or OHS. Only 15% of workers have access to OHS and the global coverage of labour inspection and occupational safety inspection is likely no higher than 20% (59, 67). Countries show an implementation gap due to several reasons including lack of political priority, insufficient coverage of legislation, weaknesses in enforcement and inspection systems and shortages of infrastructures for services associated with lack of trained human resources.

Value-based policies warranted

As evidenced by evaluations, a country's political setting impacts on both ratification and implementation activities (65, 66). In addition to the power of governments, unions, employers, corporations and scientific experts (among other actors), the influence of political ideology, beliefs and values cannot be forgotten in real-life situations. This holds true even if the political nature of public health policy is often reduced to financial or technical value-free processes (67, 68). In conjunction with numerous NGOs, the ILO and WHO make global efforts to encourage national governments to adopt more value-based policies, 'right to work' and 'rights at work' principles. This is further justified as the growing body of evidence shows positive employment, health, safety and economic impacts from the Decent Work programme (17, 30).

Vertical ownership, horizontal collaboration

Sectoral (vertical) organization has been and, with good justification, continues to be the universal model for public governance in well-organized societies. Like those for health, the challenges of modern working life are growing in complexity. Ownership and ultimate responsibility for health belong to the health sector; similarly employment and work life belong to the labour sector. Without special actions the sectors traditionally do not collaborate well, although many of the challenges raised by rapidly changing globalizing work life and the health and safety of working people need integrated, multisectoral approaches that do not prejudice sectoral ownership and responsibilities. Ensuring decent employment, occupational health and safety and OHS for every working individual is a shared responsibility of international organizations, governments, occupational health authorities, social partners, community authorities, individual employers and their associations, individual workers and their unions, organizations of the self-employed, community interest groups; professional associations and other NGOs, academia, researchers, educators, and experts. The ILO recommends multisectoral government advisory or governance councils – as well as councils or committees at intermediate and workplace levels – for planning, implementation and follow-up of policies and programmes for decent work, OSH and OHS (52).

Regulation, accountability

Globalization means that all countries need to strengthen democratic governance at national level, as well as public participation in the regulation and control of employment conditions. Full employment policies and regulation need to be promoted in order to reduce the health inequalities associated with unemployment, precarious employment and informal work. But regulation without implementation is worthless. Formalization and registration of informal work is the way to ensure wider coverage, better implementation of standards and provision of services to the underserved. International organizations propose government-led national economic and industrial policies devoted to full employment, enforcement of fair employment standards and universal education. The ILO proposes that zero tolerance policies should be applied globally to regulate the most extreme violations of human rights, worst forms of child labour, bonded labour, slavery and human trafficking (8, 17, 69).

Financing

Governments should ensure sustainable financing for employment services that reintegrate people at risk of unemployment and excluded from access to OSH activities and to OHS. The employer holds primary financial responsibility for

establishing safe and healthy working conditions; health and safety at work, OHS, and insurance for occupational accidents and diseases (50). Public financing interventions should be used in cases where there is no employer (self-employed, informal economy) by utilizing appropriate public insurance mechanisms or tax revenues. Adequate and just compensation for occupational accidents and diseases shall be ensured for every worker. Within social policy, government should ensure that all workers have adequate social insurance for sickness, disability, maternity and unemployment (50, 64).

Need for service infrastructures for all

Practical implementation of national policies and programmes requires strengthening of infrastructures, human resources and practical activities for full employment, OSH inspection and OHS services. The BOHS approach may support health-care programmes by bringing employers, workers and enterprises closer to the health sector.

ILO and WHO policies request full coverage by OSH services and OHS, adjusted to the health and safety needs of every workplace and every worker. Evaluation research and practical experience emphasizes the need for true occupational health competence in OHS provision, including protection of workers' health, prevention of safety and health risks, and promotion of health and work ability. However, the high proportion of the total workforce within the small enterprise, self-employed and informal sectors makes it difficult to provide specialized OHS. Hence, the introduction of BOHS: intended for use in primary health-care service infrastructures and channels for the provision of competent OHS by trained OHS personnel. Several countries have implemented or piloted BOHS and some have integrated BOHS within their national health systems (35, 55–57, 70).

Human resources

Every government should ensure the availability of adequate training and education programmes, not only for employment services but also on OSH for employers, workers, occupational safety officers and inspectors, and occupational health experts providing services. The quality and competence of training and education programmes and the achievement of training objectives should be ensured and controlled by the certification of trainers, either by government or by a government-authorized national body (15, 16).

Information and research

Up-to-date and user-friendly information and evidence-based analysis on working conditions, safety and health should be made available for government,

social partners, experts, employers and workers. The National Occupational Safety and Health Information Centre (CIS Centre) should be established in every country, in accordance with ILO guidance (62). Research on work life and OHS should be institutionalized in every country by including occupational health as a priority on national research agendas. Governments should ensure the sustainability of such research with the help of independent national institutes for work life or OHS, other relevant research institutes and academia. In addition to research on managing the hazards and challenges of traditional and modern work life, the research agenda should include service systems; the economic impact of decent work; and prevention of safety and health hazards (48, 52).

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Chapter 8

Promoting mental health: a crucial component of all public policy

Rachel Jenkins, Alberto Minoletti

Key messages

- Integration of mental health and physical health is essential for mental health to become an integral part of any health policy-making.
- In general, successful integration of mental health within other policy areas requires an understanding of the goals and language familiar to the other sector.
- Positive mental health should be a priority in public policies given its importance for quality of life, social relationships, productivity and social capital, and for the high burden associated with mental ill-health worldwide.
- A number of effective interventions are currently available for mental health promotion, most offering outstandingly good value for money. These foster positive mental health through the main determinants of mental health; intersectoral actions to strengthen protective factors and diminish risk factors; and emphases on socioeconomic conditions, community networks and individual resilience.
- The call to scale up care for mental disorders needs to be matched by a call to integrate mental health promotion within general health action.
- Overcoming the barriers for intersectoral collaboration in mental health promotion requires political commitment; adequate legislation

and government structures; leadership for mental health; and, often, development of a shared mission and key objectives, tangible strategies and measurable goals and targets.

8.1 Introduction

WHO has defined mental health as: "... a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (1). In this sense, it is more than just the absence of symptoms of mental illness and refers to the foundation of an individual, to quality of life and capacities. Positive mental health has an important societal value, contributing to the functions of society, including overall productivity. It is an important resource for individuals, families, communities and nations, contributing to human, social and economic capital. As a concept, mental health promotion generally focuses on the achievement of positive mental health (what can be done to maintain and improve good mental health) rather than on prevention or treatment of mental illness (2).

The determinants of positive mental health may be clustered into three key categories: socioeconomic conditions, social capital and individual resilience. Research has demonstrated that several indicators of socioeconomic status are positively correlated with mental health, including income level, years of education, employment status, housing quality and neighbourhood conditions (3–6). Similar factors have been extensively proven to produce adverse effects on physical health (7).

Social capital includes features such as networks, norms, reciprocity and social cohesion; creating a sense of belonging, social support, a sense of citizenship and participation in society (8). Belonging to a social network involving communication and supportive relationships is protective of good health and positive well-being. Strong links between social support and mental health have been found in studies of positive mental health and of mental ill-health. A culture of cooperation and tolerance between individuals, institutions and diverse groups in society is a protective factor for positive mental health. Research on social capital has specifically pointed to community cohesion's important influences on mental health, involving levels of trust, reciprocity and participation (9).

In relation to the individual, factors such as self-esteem; life satisfaction; optimism; coherence; the ability to deal with thoughts, feelings and to manage life; emotional resilience; and the ability to cope with stressful or adverse

circumstances have been found to be closely linked with positive mental health (9).

There are considerable equity issues in mental health and mental illness (10) such that women; people of older age; people who are separated, divorced or widowed; women who are married and men who are single; people in debt; people in poor housing; people who have been bullied or sexually abused; and people who are in poor physical health have a lower probability of achieving adequate levels of mental health. An OECD report on measuring well-being in different countries shows that people with lower levels of education or with disability report lower life satisfaction, and women report lower positive affect balance (3).

Mental health and physical health are closely interlinked and are both essential components of general health in the individual. Emotional well-being is a strong predictor of physical health and longevity; sustained stress and psychological trauma increase susceptibility to physical illness. For example, psychological stress, depressive and anxious feelings can increase the risk for cardiovascular diseases. They also produce adverse changes in neuroendocrine and immune functioning that increase susceptibility to a variety of physical illnesses (e.g. common cold). Poor mental health contributes to unhealthy behaviours such as poor diet, sedentary lifestyle, smoking, drinking and unsafe sex (11). Conversely, mentally healthy adults present a low risk of cardiovascular diseases; the lowest number of chronic physical diseases with age; the fewest health limitations of activities of daily living; and lower health-care utilization (4).

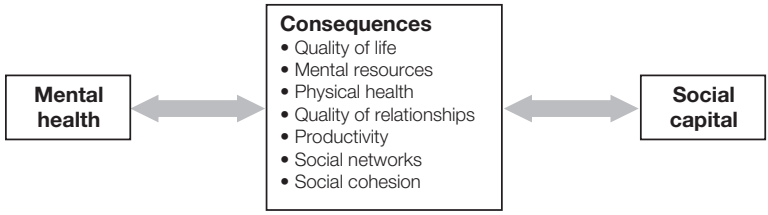
Positive mental health can reinforce quality of life, social relationships, productivity and social capital, and vice versa. The intrinsic value of positive mental health has been increasingly recognized in recent years and a range of favourable outcomes for education, work and economy has been identified. Several studies have demonstrated that several positive mental health attributes are associated with good academic achievement at school (12, 13) and adequate performance at work (4, 14). As a societal value, mental health has been related with the concept of social capital. This can contribute to society's human and economic development by shaping social interactions and facilitating collective action (4). The two-way relationship between positive mental health and some of its consequences is summarized in Fig. 8.1.

Yet, more than ever before, society is placing enormous requirements on individuals who face the challenges of grappling with huge amounts of information via the Internet, newspapers, television and other social media; of handling wide numbers of social relationships and interactions via social media as well as face to face; and of handling rapid political changes and financial

uncertainties. Not enough is known about the relative impact of these stresses, or how to develop resilience and protective coping strategies.

The quantitative significance of mental health has been demonstrated mainly through the burden of disease measured as disability-adjusted life-years (DALYs). Neuropsychiatric conditions account for about 14% of DALYs worldwide, mostly due to the chronically disabling nature of depression and other common mental illnesses. Burden of disease studies have provided useful data to challenge the erroneous assumption that mental illness is not a major issue for developing countries – DALYs for mental illness could reach 10% in low-income and up to 18% in middle-income countries. At the same time, there is growing evidence that positive mental health is associated with lower rates of mortality and disability, and that this association could be explained largely by the influence of positive mental health in healthy behaviours (improved sleep, exercise and diet; reduced alcohol intake and smoking) (15).

Fig. 8.1 *Consequences of positive mental health*



Source: adapted from Lehtinen et al., 2005 (8).

8.2 Policies

Mental health promotion strategies tend to focus mostly on modifiable psychosocial and environmental determinants such as living conditions (see Chapter 3), education (see Chapter 6), income, employment (see Chapter 7), access to community resources, social support and personal competencies. Over the last 25 years, studies on mental health promotion in different countries have demonstrated that several interventions can be effective. Moreover, new studies over the last few years are showing that these interventions are seen to be outstandingly good value for money, producing a number of payoffs beyond mental and physical health (e.g. better educational performance, improved employment/earnings, reductions in crime).

Not all mental health promotion occurs under that label. For example, the education sector can (and often does) do much to promote child well-being, good school environments and antibullying programmes. All of these have a positive effect on learning capacity. Employers often work on stress management; good

management practices; sustaining careers; and work safety issues, including mental health. In this way companies gain greater productivity. Examples of intersectoral health policies based on some of the evidence described are the Health-Promoting Schools (HPS) strategy of Zhejiang Province in China (Case study 8.1) and the policy to enhance resilience and mental health through the work-life course in Finland (Case study 8.2). These illustrate ways in which the health sector works with other sectors to achieve broad objectives for people's well-being, with both health outcomes (i.e. improved physical and mental health) and outcomes typical of other sectors (i.e. improved learning capacity and work productivity).

Table 8.1 *Effective interventions for mental health promotion*

Socioeconomic conditions	Social capital	Individual resilience
Improving access to quality education for all children	Investing in intersectoral actions that promote healthy child development (Chapter 6)	School-based social and emotional learning programmes
Improving housing	Changing school ecology to create supportive environment	Stress management training
Fair employment and salary	Changing workplace environment to promote well-being (Chapter 7)	Promoting physical activity in all ages
Reducing economic insecurity with poverty alleviation programmes	Befriending for older adults (providing support in stressful situations)	Counselling and training to reduce strain of unemployment
Gender equity legislation	Strengthening social networks	Screening and brief intervention in primary care for alcohol misuse
Reducing misuse of alcohol through increased taxation		
Antidiscrimination legislation contributing to respect of diversity		

Source: Hosman & Jané-Llopis, 2005 (16); Knapp, McDaid & Parsonage, 2011 (17); Roberts & Grimes, 2011 (18); Kalra et al., 2012 (2).

Mental health promotion may include both promotion of awareness about mental health and mental illness, and promotion of the mental health of the general population and of those with mental illness. The Egyptian case study (Case study 8.3) describes a campaign which addresses both aspects.

Case study 8.1 *Health-Promoting Schools strategy in the Zhejiang Province of China*

Carmen Aldinger

The Chinese policy for quality education was initiated around 2000 with a focus on the "whole child" (19). WHO's Global School Health Initiative was launched in 1995 with an initial focus on the world's most populous countries. Together, these prompted the development of the HPS strategy in China. The Chinese national government selected Zhejiang Province as the place for pilot studies and scaling-up, with WHO support. The main stakeholders

Case study 8.1 *contd*

advocating for political support were the ministries of education and health at national and provincial levels. The HPS strategy was integrated into the broader policy of quality education focusing on academic achievement and also on the child's physical, social and emotional development; addressing the high academic pressures (partly related to China's one-child policy) which were one of the most significant mental health challenges in this province. There was also a need for effective communication between students and teachers and between students and parents concerning students' physical and mental health (20).

Following successful pilot projects from 2000 to 2002, the provincial departments of education and health jointly decided to scale up the HPS initiative systematically over the entire province of 47 million people. This was planned with the support of WHO. The first phase of scaling-up lasted from 2003 to 2005. While the pilot projects in Zhejiang Province focused on tobacco use prevention and healthy nutrition, the scaling-up addressed additional health topics, including mental or psychological health. The whole-school approach included a variety of interventions ranging from structural to community and individual level. Health and mental health professionals as well as educators were involved in designing and delivering the programme. Schools found innovative ways to obtain funding for the activities, including funds from town governments. Interventions included: encouraging a caring atmosphere and good relationships between teachers and students; implementation of student support groups; increased use of participatory learning methods; integration of health topics into regular teaching; annual medical check-ups; prevention of common diseases; morning exercises and improved sports facilities; psychological consultation and hotlines staffed by specially trained teachers; teaching parents about health; and providing teachers with consultancy advice about mental health problems in schools.

An evaluation found that schools had implemented interventions that addressed all HPS components: school health policy, physical school environment, psychosocial school environment, health education, health services, nutrition services, counselling/mental health, physical exercise, and health promotion for staff. This contributed to improving the psychosocial atmosphere and establishing more harmonious and caring relationships. Most of the components of HPS also contributed to physical, mental and social aspects of comprehensive health promotion (21).

Case study 8.1 *contd*

Success factors included creation of HPS planning committees which established policies and workplans; prioritizing health by incorporating the 'Health is First' concept within all school activities; and effective communication about the HPS concept. Challenges comprised the complexity of understanding the HPS concept; and the need for professional development and support (22).

In early 2013, almost ten years after the first phase of scaling-up began, the HPS strategy is still sustained in Zhejiang Province and includes about 1000 schools. Recently, the provincial departments of health and education jointly issued a document on HPS development which includes making the evaluation, training and awarding of HPS status a 'normal' part of their activities.

8.3 Politics

Relevant actors for mental health promotion policies include politicians, civil servants, professionals in all sectors, nongovernmental agencies, social movements, communities and the media. However – despite growing evidence of positive mental health's value to society and of effective interventions to enhance mental health – attention to mental health promotion remains low on both public health and general social political agendas.

The lack of a balanced approach to mental health policy – that is, assigning equal weight to mental health promotion, prevention, treatment, rehabilitation and prevention of mortality – is one factor that has reduced policy-makers' awareness of positive mental health. Acceptance of the urgent need to improve services for people affected by mental illness and to defend their human rights has undermined mental health promotion and prevention, as well as prevention of mortality. Similarly, within health promotion, physical health promotion has been emphasized while mental health promotion has been relatively neglected. Mental health promotion has also been insufficiently emphasized within global initiatives. For example, in recent years WHO has focused largely on the treatment gap for mental disorders and how to scale up services. WHO's development of a new Global Mental Health Action Plan 2013–2020 could signal a change in this trend as the zero draft includes promotion as part of the goal and one of the four objectives.

A second problematic factor concerns confusion about the meaning of the term 'mental health'. Not only advocates but also professionals and policy-makers often use this term to refer to mental illness, its treatment and services.

Although an understandable effort to reduce the stigma attached to the term 'mental illness', this makes the meaning of positive mental health and related interventions even more invisible. Of course, from an equity and human rights perspective the goal of positive mental health is as important for people with mental illness as it is for the rest of the population (see Case study 8.3). The EU has made considerable efforts to promote the concept of positive mental health since the mid 1990s, but progress has not been as fast as might have been hoped.

Mental health promotion needs to be integrated properly within general health action. Indeed, as already noted, mental health needs to be promoted for the general population; for people with mental illness and for people with physical illness, or both. Children of sick parents require particular attention, as recognised by legislation in some countries – the health services caring for a seriously ill parent must ensure that the mental needs of his/her children are assessed and addressed (see Chapter 6).

There have been important advances in establishing an evidence base for interventions that contribute to promote mental health wellness. However, as yet there is insufficient experience of incorporating such interventions into policy formulation and implementation, even in high-income countries. Further investigation and evaluation of policies being implemented is needed to build a case for the promotion of mental health as convincing as that developed for the treatment of mental illness. Given the complexity of psychological phenomena and the limitations of the available measurement tools, the field of mental health faces major challenges in defining indicators for mental health promotion and evaluating levels of achievement (23). Despite these difficulties, in recent years there have been promising advances in the methodology to assess positive mental health indicators (5, 24).

As with general health, it is increasingly recognized that implementation of mental health promotion policies proven to be effective requires initiatives that go beyond the health sector. However, it is not always easy to place mental health on the agenda of other sectors. Skeen et al. show this in a recent study in South Africa where it was found that intersectoral collaboration was largely insufficient despite widespread awareness of the cross-cutting nature of mental health issues and the links with different sectors. The need to develop legislation and government structures to support intersectoral action was one of the main lessons emerging from this study that could be useful for other low- and middle-income countries. Formal agreements among different stakeholders, tangible strategies and measurable goals and targets may also be needed. At the same time it seems necessary to create a culture of collaboration between different sectors, with joint activities for the exchange of views and knowledge,

and definitions of roles and responsibilities for mental health that consider the priorities of the various sectors. Leadership for mental health in the health sector and beyond is also important, as is work involving municipalities and civil community groups at local level (25).

The CSDH made three general recommendations: (i) improve daily living conditions; (ii) tackle the inequitable distribution of power, money and resources; and (iii) measure and understand the problem and assess the impact of action (7). These offer many entry points for interventions proven effective for mental health promotion and for evaluation of the impact of different actions on positive mental health. The CSDH has gained political momentum for considering health equity in all policies which, in some countries (according to their particular cultural, social and political circumstances), may help to generate windows of opportunity to integrate mental health promotion into health actions included in other sectors' policies (see Chapter 4).

Recently, countries in the European, African and Eastern Mediterranean Regions made efforts to mainstream mental health into the Political Declaration of the General Assembly on the Prevention and Control of Non-communicable Diseases. Their lack of success demonstrates how mental health is still stigmatized within the highest levels of international policy-making on mental health, and how far there is to go to achieve full integration (26).

Mental health promotion is based on the underlying principle that it is an integral part of overall health and therefore of universal relevance. As articulated in the Ottawa Charter for Health Promotion (27), in addition to building healthy public policies, the principles of health promotion practice are based on an empowering, participative and collaborative process which aims to increase control over health and its determinants. Reviews have identified key health promotion strategies necessary for successful implementation: community participation and engagement in planning and decision-making; intersectoral collaboration and interorganizational partnerships at all levels, involving multiple sectors such as governmental and nongovernmental organizations, groups and local stakeholders; creation of healthy settings, focusing particularly on the settings of schools, workplaces, cities and communities; and political commitment, funding and infrastructure for social policies (28). The Finnish example (Case study 8.2) demonstrates how actors outside the health sector can work collaboratively to develop strategies that promote mental health through the work life (see also Chapter 7).

The United Kingdom of Great Britain and Northern Ireland provides an example in which consistent efforts eventually resulted in a cross-government mental health promotion strategy. Both research and persistent advocacy (inside

Case study 8.2 *Enhancing resilience and mental health through the work-life course in Finland*

Jukka Vuori, Juhani Pirttiniemi

Individuals need resources and resilience to endure career transitions, job insecurity and job loss in a rapidly transforming work life. In Finland, career preparedness for challenging career transitions has been increased through group interventions for promoting better career outcomes and for preventing depression.

Developed at the Finnish Institute of Occupational Health, in collaboration with the Ministry of Labour and the National Board of Education, several interventions have been applied in various phases of the work-life course. This intersectoral collaboration was initiated in areas of high political priority. The starting points were the severe recession and respective *Työhön* (To Work) experiments for the unemployed during the 1990s (29). Simultaneously, a labour market policy reform was carried out emphasizing active resource-related measures and job-search training. This reform boosted the scaling-up efforts of the *Työhön* method as it focused on increasing preparedness for re-employment including both the infrastructure, tools and experience for training new trainers quickly and the potential for larger scale delivery of the method package.

Two other group methods focused on critical transitions during entry to work life (30, 31). These methods were implemented in the educational institutions as the need for graduating students to be better integrated into work life was recognized as a major political problem. Implementation included intersectoral collaboration with the labour administration, which had prior experience in the methodology. The newest method was developed to enhance employees' resilience and mental health in changing organizations (32).

Four randomized controlled trials demonstrated that increasing preparedness during these transitions results in better career outcomes and mental health, especially among those at risk for depression. All these group interventions have been published and disseminated widely into practice. FIOH has provided training of group trainers in labour offices, schools and work organizations and distributed method publications. Altogether, over 1300 trainers have been trained and over 60 000 people have participated in training.

and outside government) since the late 1980s finally created an environment in which it was reasonable for a major government think tank to consider the issue. The government's Foresight Programme acts as a think tank on science and technology issues. Using the best available evidence to provide visions of the future, its aim is to assist policy-makers to develop strategies to identify potential risks and opportunities and thereby manage them better. Projects are led by the government's Chief Scientific Officer and are cross-departmental in nature.

The Foresight Project on Mental Capital and Wellbeing was initiated in 2006 and reported in autumn 2008; undertaken in recognition of the challenges that the United Kingdom of Great Britain and Northern Ireland (in common with all nations) faces in a rapidly changing world. These include the demographic age shift; changing nature of the global economy and work patterns; and the expectations, attitudes and values that will change with these characteristics. The aim was to advise the British Government on how to achieve the best possible mental development and mental well-being for everyone in the country. Using the best available evidence to develop a vision for the opportunities and challenges facing the country over the next 20 years and beyond, the Foresight Project addressed the implications for the population's mental development and mental well-being. Over 400 leading experts and stakeholders from across the world were involved in a process which brought together scientists and policy-makers in a variety of forums. More than 80 state-of-science scientific reviews were conducted across a wide range of disciplines including economics, the social sciences, neuroscience, genetics, psychology, psychiatry, education and occupational health. The report adopted and developed a life-course approach, demonstrating how both positive and negative influences may impact on a proposed trajectory at each stage of a lifetime.[1] The findings were discussed extensively across government departments and stakeholders, culminating in a cross-governmental public mental health strategy in 2011 (33).

Thus, the Foresight Project effectively created a window of opportunity to encourage government departments to consider mental health across all sectors. The dialogue about positive mental health continues in parliamentary committees, public debates and media articles; and is increasingly reflected in public health strategies and training for different sectors and professionals. The United Kingdom of Great Britain and Northern Ireland is exploring methods for routine data collection on positive mental health at population level. Health impact assessments of policy provide a useful tool to ensure health, including mental health, and should be considered in the construction and appraisal of policy. Indeed, all public policy provides a window of opportunity in which to

1 The main findings of the report are available online (http://www.foresight.gov.uk).

consider the implications for mental health and opportunities for inclusion of effective mental health promotion interventions. This requires mental health policy-makers to establish effective cross-governmental collaborative and win-win linkages, and to make efforts to limit damage to mental health where such policies present serious risk (34).

8.4 Implementation issues

The example of the Foresight Project demonstrates how review of the evidence base, launched under the auspices of government, was able to lift the mental health promotion agenda to a much higher and more wide-ranging level than ever before, capturing not just the health sector but across all government sectors.

Good governance is crucial for implementation of mental health promotion; a supportive and favourable policy context is essential to ensure that mental health promotion efforts are sustained (35). This includes explicit inclusion of mental health promotion not only within the national mental health policy and strategic action plan, but also in the national health policy and strategic action plan or health sector reform strategy. This includes resource allocation to research, planning, training, implementation and monitoring. Thus, within the health sector, mental health promotion will need to be explicitly considered in research priorities, health management information systems, human resource development (basic training, post-basic training and continuing professional development of all relevant cadres) and service developments in primary health-care and in specialist health-care. Within the education sector, mental health promotion will need to be considered in the national education policy and strategic action plan; and in research priorities, education information systems, teacher training, curriculum development and school organizational issues. This will ensure that positive mental health and mental illness are addressed within the general health components of every policy, and included in training and procedures for their staff.

The Zhejiang case (Case study 8.1) is a good example of how a national education policy can be applied in a province with a mixed strategic action plan of education and health, where research plays an important role evaluating pilot projects, and teachers are trained on health topics and to carry out psychological consultations. Similar considerations apply to the sectors of social welfare, employment, police, court, prison service, probation service and child protection (36). One potential lesson from the Finnish example (Case study 8.2) is the importance of choosing points of intervention carefully (transitions in the work-life course) and the need to install policy as an integral part of the

activity of other sectors. This also stresses the importance of other sectors seeing potential benefits for their own goals.

Political commitment needs to be mobilized to give mental health greater priority in policy development, including policies which promote mentally healthy living, working and social environments. As previously discussed, political commitment in the United Kingdom of Great Britain and Northern Ireland was gained through the Chief Scientist convening meetings with ministers, the Prime Minister and the head of the Civil Service, placing expectations on ministries to promote mental health in their policies. Public participation is critical to this process as policy development needs to be based on greater public awareness of what mental health promotion can contribute to wider health and social gain (37) and on engagement with good mental health's importance in overall health and social well-being. In other words, the visibility and value of mental health needs to be enhanced (36).

Historically, civil society and NGOs have played a large role in fighting for improved human rights and care of people with mental illness. They could do more to advocate for action on positive mental health but, to some extent, their activity reflects their funding base – the public do not yet consider promotion of positive mental health to be a charitable cause worthy of donations relative to other charitable causes. As Moodie and Jenkins point out, there is a persuasive case for governments to invest in mental health promotion as an effective strategy for creating health and social gain (38). The WHO's Mental Health Action Plan for Europe (39) advocates making mental health an inseparable part of public health. Jenkins et al. (36) discuss the importance of mental health promotion and mental health monitoring in overall policy, and point to the importance of addressing national components, support infrastructure and service components. National components of mental health policy that need to be considered include legislation; the national strategy; policy links with other government departments (e.g. housing, employment, education); mechanisms for implementation and accountability; and funding streams. Support infrastructure for mental health policy includes strategies on health information; research and development; and human resources. The service components of mental health policy include mental health promotion in schools, workplaces, health services, the criminal justice system, communities and NGOs.

The socioenvironmental nature of the determinants of mental health demand a cross-sectoral approach involving the building of partnerships and collaboration across a range of government departments, different sectors, agencies, organizational and community groups. Rowling and Taylor (40) describe the most significant components of an intersectoral approach to be adoption of

a shared unifying language with which to work across sectors; a partnership approach to allocation and sharing of resources; and strengthening of capacity across individual, organizational and community dimensions. Key features for building collaborative partnerships include choice of an organizational structure for intersectoral collaboration; development of a shared mission and key objectives; establishment of clear roles and responsibilities; clear lines of communication; engagement of the whole community through careful wide representation; building relationships; developing collaborative leadership; building core competencies and capacities; fostering action; and ensuring management skills (28).

Implementation may fail for reasons including lack of a focused and targeted approach to programme planning, implementation and evaluation; of underpinning theory; of attention to identified research factors for efficacy; of preliminary needs assessment before planning; of empowerment, collaboration and participation with stakeholders; of a competence enhancement approach; of a comprehensive approach addressing a range of protective and risk factors, operating at different levels, and at different time points; and, finally, of training and support for those responsible for implementation (28).

Case study 8.3 *Awareness campaign on mental health and rights of people with mental illness in Egypt*

Nasser Loza, Fahmy Baghat

From 2006 to 2011, the General Secretariat of Mental Health at the Egyptian Ministry of Health and Population ran an advocacy campaign with the theme: One Community Accepts All. This aimed to raise awareness and change Egyptians' conceptions and attitudes regarding the nature of mental illness, therapeutic approaches and the rights of people with mental illness. This campaign was timely support for the development, enactment and implementation of the 2009 legislation on the treatment of people with mental illness. Respect for the rights of people with mental illness could be achieved only through valuing the service users, their carers and professionals.

The advocacy campaign used television, short animation videos, street billboards, online materials disseminated through a dedicated web site, posters, community workshops, printed reading materials and radio programmes to reach the population. One example contains a narrated encounter between a job applicant and a human resource manager – the former is rejected on the basis of his psychiatric history. Service users, caregivers, nurses and psychiatrists in the field were invited to appear on television talk shows. Egyptian culture is traditionally spiritual at its base, so

Case study 8.3 *contd*
the appeal to righteousness encouraged protection of vulnerable individuals in the community.

The campaign worked through schools and universities. Mass communication faculties included the message in their educational programmes. Medical student associations from 10 universities arranged seminars and public awareness events including a cycling rally through the streets of Cairo to raise awareness of mental illness. Professional media producers volunteered advocacy tool kits and productions.

Programmes for physicians, nurses and social workers strengthened implementation of the human rights approach embedded in the new Mental Health Act. Advocacy tool kits were produced for dissemination at primary health-care centres. The large mental hospitals were opened up to the community, human rights organizations were invited to inspect them and the media invited to report on the living conditions. Parliamentarians, judges, prosecutors, lawyers and activists participated in community awareness events and training workshops focusing on human rights aspects for service users at psychiatric facilities.

Documentary films interviewing service users were produced, as well as exhibitions of photographs exposing living conditions within those hospitals. The single most effective approach in the campaign was the opportunity for service users to be heard. A long-term inpatient at Abbassia Hospital was invited to Parliament to speak on the experience of being a patient in a psychiatric facility for decades. In collaboration with Cairo University, a study was implemented to evaluate the campaign's impacts on the Egyptian community.

8.5 Conclusion

The need to promote positive mental health is a crucial component of all public policy across all government and nongovernmental sectors. This requires considerable political commitment and intersectoral collaboration. Aided by the growing evidence base and capacity to measure indicators for positive mental health, a number of countries have made progress. More investment in research on mental health promotion is likely to pay huge dividends to society.

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Chapter 9

Agriculture, food and nutrition

Stuart Gillespie, Florence Egal, Martina Park[1]

Key messages

- Malnutrition tends to be most prevalent among poor rural communities who are also most dependent on agriculture for a livelihood.
- Globally, there is a struggle to get to grips with a double burden of coexisting undernutrition with overweight and obesity.
- Agriculture, nutrition and health are entwined in many ways – positively and negatively – but individual policies and programmes still operate largely out of sectoral silos.
- Sustainable improvement of nutrition requires an integrated approach combining agricultural and public health interventions.
- Gender-sensitive food and agricultural interventions aimed at sustaining livelihoods and increasing availability of, and access to, diverse and nutritious foods within poor rural communities need to be combined with preventive and clinical interventions provided by the health sector.
- Better governance at all institutional levels (in terms of fostering intersectoral collaboration and harmonized policy-making) needs to be matched by community-level convergence of agriculture, nutrition and health services and programmes that takes full account of local priorities and needs.
- Recent years have seen growing momentum for a more concerted, enlightened focus on tackling malnutrition that takes heed of its multiple

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causes and seeks to incentivize various sectoral actors to come together. The Scaling Up Nutrition (SUN) and the 1,000 Days movements are leading examples.

9.1 Introduction

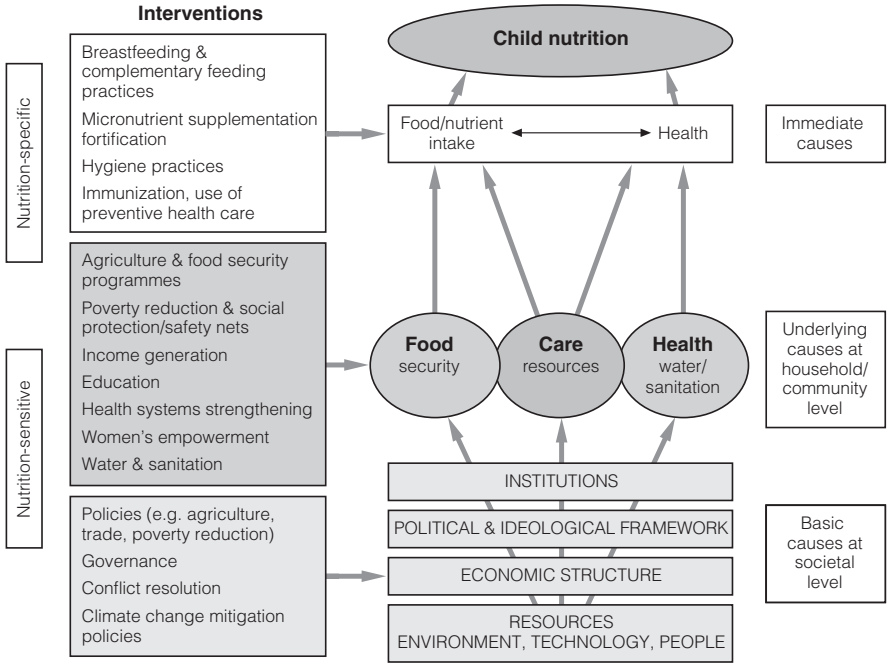
Nutrition is foundational to the development of both individuals and countries and to the achievement of all major social and economic goals, including the MDGs. Undernutrition in early life is responsible for 35% of deaths of children under five years; reduces cognitive attainment through various routes; substantially increases the likelihood of being poor throughout adulthood; and has a close link with illness or death during pregnancy and childbirth for both mothers and their babies. Increasingly, in poorer parts of the world, countries are facing what is referred to as the double burden of malnutrition – acute and chronic malnutrition, as well as micronutrient deficiencies, increasingly coexist with overconsumption of energy-rich foods in other population groups, all of which are signs of inappropriate diets (1). NCDs – many of which are caused or aggravated by excessive body weight – are quickly gaining ground.

Undernutrition shows an ongoing disturbing global situation: almost 200 million of the world's children under five are stunted. India contains more than one third of all undernourished children and, at current rates of progress, will meet the MDG underweight target only in 2043, not 2015 (2). The latest data from the United Nations Standing Committee on Nutrition (UNSCN) indicate that only 18 of 42 African countries show improvement in underweight rates, while 14 show deterioration (3). This is unacceptable and puzzling – consideration of the drivers may explain the lack of progress.

The conceptual framework pioneered by UNICEF in the early 1990s (Fig. 9.1) clearly shows the determinants of malnutrition at different levels and the type of sectoral responses that may be appropriate for responding effectively. Since poor nutritional status is the final outcome of a combination of determinants clustered into food, health and care, it is generally agreed that alleviation of malnutrition will require the integration of food security, public health (including water, sanitation and hygiene) and social protection. This is a multifaceted problem requiring multisectoral solutions. Fig. 9.2 shows the interaction of four *systems* — agrifood, environmental, health/disease and, crucially, the system of individual and household decision-making.

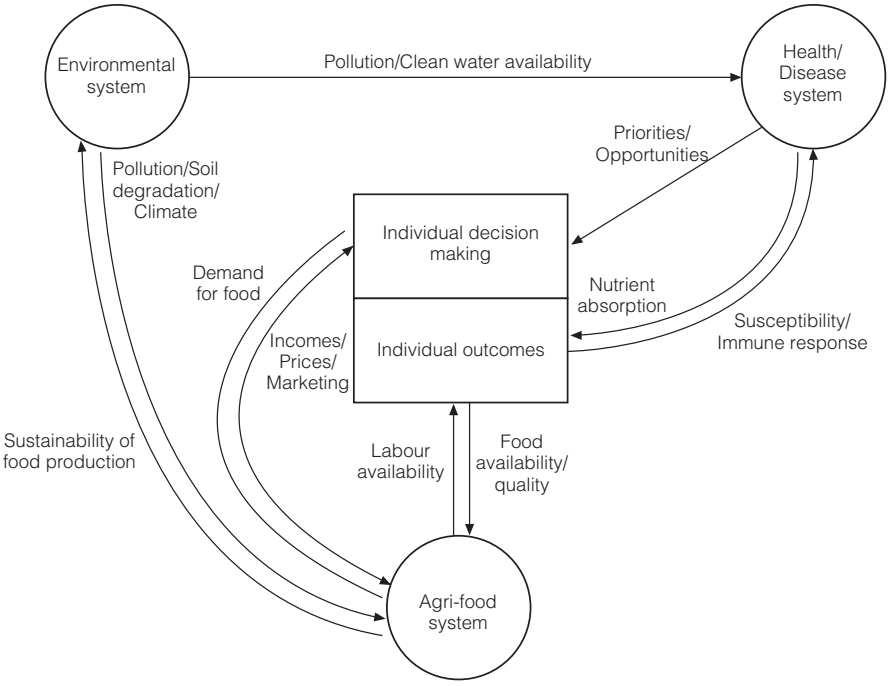
Nutrition is increasingly perceived as a major development problem and it is generally agreed that agriculture and health are both prerequisites for good nutrition, yet both sectors tend to neglect this. Agriculture produces the food people eat and is the primary source of livelihood for the majority of the world's

Fig. 9.1 *Conceptual framework of drivers and determinants of undernutrition*



Source: modified from UNICEF, 1990 (4).

Fig. 9.2 *A systems framework for food and nutrition security*



Source: Hammond & Dubé, 2012 (5).

poor who, in turn, are most vulnerable to ill-health and malnutrition. The interactions between agriculture and health are two-way: agriculture affects health, and vice versa. The process of agricultural production and the outputs it generates (including fibre and materials for shelter; bioenergy for cooking and heating; medicinal plants) can contribute to both good and poor health, among producers and the wider population.

Agriculture contributes to livelihoods and food security through direct production of food and by generating income that can be spent on food, education and health care that benefit nutrition. The TANDI (Tackling the Agriculture-Nutrition Disconnect in India) initiative of the International Food Policy Research Institute (IFPRI) has highlighted potential trade-offs, especially with regard to the role of women in agriculture. Women's and children's nutritional status may suffer if a rise in the demand for female agricultural labour is not matched by enhanced decision-making power and control of household resources, including time (6). Gender is closely intertwined with nutrition. And yet both agriculture and health sectors continue to view gender from narrow perspectives: the health sector focuses on the reproductive role of women; the agriculture sector looks mainly at their productive role (see Chapter 3).

As well as undernutrition, agriculture is associated with many other major health problems, including malaria, HIV/AIDS, foodborne diseases, diet-related chronic diseases and a range of occupational health hazards. Agriculture can contribute to both the spread and the alleviation of these health conditions. Conversely, undernutrition and poor health have tremendous implications for agriculture, influencing market demand for agricultural products, as well as their supply. Agricultural workers who are malnourished and/or in poor health are less able to work. This cuts productivity and income, perpetuating a downward spiral into ill-health and poverty and further jeopardizing food security and economic development for the wider population. Successful health policies benefit agriculture by protecting the labour force from days (and income) lost to illness, chronic disabilities or mortality (7).

Environmental changes such as global warming, desertification and loss of agrobiodiversity, and increasing use of food crops for non-food purposes in the face of energy crises, are further jeopardizing food security. Simultaneously, global economic and social changes are transforming food systems at an unprecedented rate; increasingly superimposed by marketing systems which demand food production to be intensified and standardized. While the landscape of agrifood business continues to be quite diverse, value chains tend to increase the power of retailers and supermarkets rather than producers. In consequence, retailers' needs for high food-safety standards; traceability throughout the value

chain; standardization; and steady supply generally lead to a focus on a few large suppliers and make access to global markets more difficult for smallholders. Ultimately, these processes are accompanied by progressive marginalization of family agriculture, degradation and loss of (agro)biodiversity. This further jeopardizes the food and nutrition security of agricultural producers in developing countries. However, smallholders continue to play a crucial role in supplying local markets with fresh and affordable agricultural produce. National policies need to respond to the needs of these multiple and often conflicting governance structures (8), finding a balance between supporting agricultural producers' connections with globalized value chains while meeting the needs for diverse and fresh foods in 'traditional' local markets.

The consequences of increasing globalization of value chains reach well beyond the agricultural production system, however. The emergence of fast food outlets and supermarkets; intensification of advertising and marketing of comparably cheap industrialized products; foreign direct investment in developing countries; and acceleration of urbanization, often translate into changing dietary patterns. Specifically, an overall increase in consumption of energy-dense foods. Associated changes in lifestyles and occupational patterns lead to a shift from home-prepared and home-based meals to pre-prepared or ready-to-eat meals. These are often consumed away from home which, combined with decreased physical activity, leads to rises in obesity and diet-related chronic diseases (9).

Against this backdrop, this chapter addresses the core question: How can the convergence between agriculture, health and other sectors be strengthened in order to reduce malnutrition more effectively and sustainably?

Recent efforts have promoted scaling-up of quick impact evidence-based interventions[2] but limited efforts have been made to address institutional challenges that beset convergence of nutrition-relevant sectors. Sectoral policies must incorporate consideration of nutrition (become nutrition sensitive) and be articulated so as to provide populations with the integrated support they require. Most countries have not tapped the agricultural sector's potential to address undernutrition, as will be seen in the rest of this chapter. Moreover, if the agriculture and food sector works more closely with the health sector, the rising prevalence of diet-related NCDs and early deaths can be reduced through better nutrition and healthier lifestyles. The global food system has evolved over the past century to deliver a number of benefits: greater choice for consumers, greater food diversity and lower cost. But the food and agriculture sector must ensure that consumers can access an adequate mix of locally available, less-processed and culturally appropriate items for diverse and sustainable diets.

2 See The Lancet Series on Maternal and Child Undernutrition, 2008 (http://www.thelancet.com/series/maternal-and-child-undernutrition).

9.2 How 'nutrition sensitive' are agricultural policies and programmes in regions of high malnutrition?

The paucity of studies evaluating agriculture's impact on nutrition outcomes further reflects the disconnect between food production and food consumption in the minds of agronomists and economists. Studies on the commercialization of agriculture tend to show that such interventions effectively increase income and food expenditures but usually do not show improvements in child nutrition. Yet, it is important to note that this can often be explained by the fact that project designers and evaluators often fail to look at the *nutritional* impact of their interventions, confining their analyses to impacts on food availability or household income. Like many previous studies, a recent comprehensive review by Masset et al. (10) concluded that agricultural interventions per se had been found to have little or no impact on child nutritional status. But importantly, and unlike previous reviews, the authors attribute this result to a lack of statistical power in the studies reviewed rather than the lack of efficacy of these interventions.

More and better evaluations that look beyond production increase, food availability and income generation are clearly needed. Policy-makers, donors and practitioners need to ensure that impact assessment of projects and programmes focuses on nutrition outcomes, or at least considers food consumption. The present rights-based movement (specifically, the right to food) should also seek to advance impact assessment of agricultural policies' effect on people's welfare and make food and agriculture stakeholders accountable for improving food consumption and avoiding negative impacts.

For many decades, the correlation between income and malnutrition has been viewed mainly from the perspective of how economic growth positively affects malnutrition rates (11). Many stakeholders, including the World Bank, have lately widely acknowledged that this mechanism works more robustly vice versa: better nutrition will boost economic development (12). The most recent cross-country evidence on the role of economic and agricultural growth in child nutritional status looks first at the productive sectors – agriculture and non-agriculture – as important mediating channels between overall economic growth and nutrition (13). Further examination considers social-sector channels such as health, education and family-planning outcomes. The study concludes that: (a) rapid economic growth is a necessary condition for sustainable reduction of malnutrition at lower levels of development; (b) *with the exception of India* (see Case study 9.1), agricultural growth tends be more nutrition sensitive than non-agricultural growth; and (c) nutrition sensitive development requires poverty reduction and social investments in health, education and family planning.

Case study 9.1 *Undernutrition in India: from problem recognition to the search for solutions*

Purnima Menon

Between 1992 and 2005/2006, three rounds of national surveys brought increasing attention to the high prevalence and slow reduction of child undernutrition in India. The data from India show that the bulk of stunting occurs in the first two years of life, with a substantial proportion of undernutrition setting in early as a result of poor maternal nutrition, intrauterine growth restriction as well as poor immediate postnatal care and feeding practices. The data also highlight high levels of early wasting, as well as poor coverage of essential inputs for addressing undernutrition.

In the Indian policy space, the national data – together with an overall global policy environment that has emphasized the importance of food and nutrition security – have led to undernutrition being seen as a stubborn national problem that needs renewed strategic focus. Since 2008, the science, policy and programme stakeholder communities in India have slowly built consensus on the centrality of the critical 1000-day period. This has led to this age group being prioritized for scaling up direct nutrition interventions. At the same time, there is an understanding that tackling undernutrition requires a focus on the underlying drivers (e.g. poverty, women's status, water and sanitation) through concerted multisectoral actions, in addition to scaling up direct health and nutrition interventions. A variety of national-level meetings have brought together many stakeholders over the last two years, leading to the development of an interministerial group on nutrition and to action points for various ministries.

The Integrated Child Development Services (ICDS) and the National Rural Health Mission (NRHM) are two current major national programmes with design and operational plans incorporating all key interventions recommended by the global nutrition community. However, actual *implementation* of these evidence-based interventions remains a primary and recalcitrant bottleneck to addressing undernutrition. In turn, this is dependent on state, district and block level capacities to tailor and scale up interventions. Impediments to progress in today's context in India include managerial issues related to field-based implementation; strengthening training and monitoring of frontline workers and their supervisors; identifying strategies for converging service delivery in the two ministries responsible for these interventions; and building greater accountability for service provision as well as greater demand for services among communities. In addition, many essential nutrition interventions (e.g. infant and young

Case study 9.1 *contd*

child feeding practices) are strongly contextual and behavioural in nature, requiring innovative strategies to scale up counselling services and to shape community norms.

India has a highly decentralized sociopolitical context and a highly variable sociocultural context across states, districts and religious, economic and ethnic communities. Hence, there are significant challenges in addressing both the direct health and nutrition-related behaviours and their underlying causes. However, the current policy and programme environment is conducive to tackling these, working with multiple stakeholders.

While Headey (13) stresses the need to invest in several sectors at the same time, another study demonstrates the importance of bridging the education and agriculture sectors in order to improve malnutrition. Ruel (14) shows that interventions which did not include a nutrition-education component failed to achieve significant impacts on nutritional outcomes. Subsequent interventions that incorporated education, social marketing and mass media campaigns together with homestead food production initiatives did demonstrate impacts. Similarly, Berti et al. (15) found that agricultural interventions that invested broadly in several different types of capital (e.g. human, physical, financial, natural, social) were found more likely to improve nutrition outcomes. A review of the nutrition impacts of interventions promoting the production of animal source foods concluded that the interventions associated with marked improvements in dietary intake and nutritional status had at least one of two key characteristics: women played a critical role in the intervention and/or the interventions included a nutrition-education component (16, see also Chapter 3). These findings are confirmed in a World Bank global review documenting a wide range of successful agricultural interventions that have contributed to improved nutrition outcomes (17). This concludes that improvement of agricultural production alone is insufficient to bring about improved nutrition. It must simultaneously address, or be complemented by, interventions addressing other determinants of nutrition such as education, improved health and caregiving, water and sanitation, gender, social equity.

9.3 How 'nutrition sensitive' is the political and institutional environment that underpins agricultural policy and practice?

Agriculture was originally developed to feed families and communities. Driven

by macroeconomic planning, the prevailing agricultural development model renders the links between people and food consumption increasingly fragile and often quite distant. The health sector aims to prevent or cure disease and is increasingly disconnected from culture and the environment. Malnutrition is generated by drivers within the purview of these two (and other) sectors and yet, more often than not, the two sectors operate independently. Opportunities for generating win–win solutions through joint policy and harmonized programming are missed as, usually, neither views the other as a key partner for achieving sectoral or national development goals (including the MDGs). This stems partly from a lack of basic awareness of the links in problems and potential solutions, partly from policy conflicts or institutional obstacles. People are often forgotten, as a silo mentality and linear incentive structures dominate. Agricultural policies address natural resource management, farmers' livelihoods, food security and food safety; public health policies tend to be focused on the provision of prevention and curative care within clinic-based health systems. Agriculture is still too often driven by an economic development rationale, while health focuses on treating and preventing disease.

Many professionals in the agriculture and health sectors (and beyond) continue to hold the simplified view that agriculture is about production and value chains, while health is concerned with reproduction. Incentives are skewed toward competition for funding of usually under-endowed ministries, not collaboration. Even where policies and plans explicitly invoke intersectoral action, implementation tends to default to the comfort zone of sectoral systems and procedures. This is further aggravated by the focus on national policies which negates local specificities and by the multiplication of top-down agendas which overlap and aggravate confusion and demand on existing institutions. The lack of a more systemic approach is reflected and consolidated by procedures which do not allow the necessary interdisciplinary collaboration, micro-macro linkages and accountability (see Box 9.1). Ultimately, there is a great need to promote shared intersectoral understanding that translates into integrated implementation of interventions that result in greater impact.

The global-level environment for nutrition has become more enabling in recent years. The SUN[3] movement is a broad-based, multi-partner initiative generating significant momentum: 34 countries have signed up to date and more are likely to follow. SUN is especially relevant as it explicitly acknowledges the importance of sectors such as agriculture in combating global undernutrition. The 1,000 Days movement[4] is another example.

3 For more information see www.scalingupnutrition.org.

4 Refers to the critical period (1000 days) from conception to a child's second birthday when his/her nutritional well-being should be protected to avoid long-term consequences (www.thousanddays.org).

Box 9.1 *Strengthening links between agriculture, nutrition and health: key constraints and challenges*

- Differences in paradigms, world views, mindsets and professional language.
- Prevailing vertical orientation of funding, budget control, organizational/sectoral planning, monitoring and accountability.
- Intersectoral issues fall through the cracks unless built into monitoring and evaluation systems.
- Competing priorities, incentives (e.g. promotion criteria) and decision-making processes.
- Complex processes of engagement.
- Capacity constraints, including: (a) rapid staff turnover (technical, managerial, political) that impedes intersectoral bridge building, and (b) out-of-date, monofocal approaches to training development professionals in universities and other institutions.

Source: Gillespie, von Braun & Ruel, 2008 (7).

9.4 What have we learnt and what can be done?

Successful and sustainable improvement of nutrition for an active and healthy life requires an integrated approach combining quick impact and longer-term interventions in relevant sectors (most importantly, agriculture and health). Food and agricultural interventions need to be (re) designed to improve access and availability for the most nutritionally vulnerable to a diverse food basket whilst ensuring livelihood security and the household's capacity to feed and care for its youngest children (see Chapter 6).

In order to realize the potential mutual benefits of harmonized policy-making and programming between the agriculture, nutrition and health sectors, certain key ingredients and processes have been shown to be critical. Eight are identified here (18).

1. Creation of an *inclusive environment* which engages all relevant partners from the very beginning in order to foster collaboration across sectors. Intersectoral bodies play a special role and tight connectivity between them and involved partners needs to be ensured. In both Malawi and Afghanistan (see Case studies 9.2 and 9.3), establishment of an intersectoral and inter-institutional body at a high political level was identified as a key factor for enabling intersectoral collaboration at all levels and to advocate for both nutrition-sensitive and nutrition-specific interventions among all stakeholders.

2. *Leadership* is key. As shown in Malawi, this requires nutrition "champions" who are articulate, persuasive and skilled in translating evidence into action.
3. Involved partners need to define *explicit objectives and modalities of collaboration* on which they all agree. Opportunities and favourable situations (e.g. policy windows) for collaboration should be seized, applying approaches to surmount barriers as well as risk management strategies.
4. Different mindsets, values and terminologies across sectors necessitate careful attention to the development of an *interdisciplinary communication system* derived from common goals; shared values and principles; and common notions of the validity of knowledge and evidence.
5. Individual, organizational and system-level *capacity* should be strengthened and realigned across sectors. Organizations can reach a broad base of expertise by either keeping a balance of representatives and experts from the different sectors or increasing the number and role of generalists and experts who cover more than one sector. Generally, teams should be given time to develop and be granted some stability in order to enable intersectoral learning for all team members. Different types of capacity are required: the example of India shows how the recent high-level discourse on nutrition needs to be matched by efforts to strengthen capacity to implement programmes – this is where the rubber meets the road.
6. New initiatives should *incentivize* development professionals to think and act intersectorally at all levels, from national to district or below. Jointly agreed and sectorally compatible monitoring and evaluation plans and mechanisms, linked to joint accountability, are important for successful intersectoral collaboration. New or adapted priority-setting and outcome-based metrics may also be helpful.
7. At the national and global level, multisectoral and interdisciplinary *policies should be reviewed regularly*, based on the progress of local strategies with resulting insights shared and policies revised according to their findings.
8. *Lessons* from successful examples of intersectoral collaboration at all levels should be synthesized and disseminated promptly. This includes impacts as well as any challenges and constraints. Box 9.2 shows some lessons learned from a multitude of experiences that were discussed at the 2011 IFPRI conference on agriculture, nutrition and health in Delhi.

Box 9.2 *Agriculture, nutrition and health: the way forward*

In February 2011, IFPRI convened a major international conference: Leveraging Agriculture for Improving Nutrition and Health. Over 1000 participants gathered to synthesize evidence and generate lessons and policy solutions. Key papers from this conference were published recently, drawing the following chief conclusions.

- *Fill knowledge gaps.* Learn more about how different patterns of agricultural growth affect nutrition and health; invest in research, evaluation and education systems capable of integrating information from all three sectors; fill gaps in governance knowledge at global, national and community levels.
- *Do no harm.* Mitigate the health risks posed by agriculture along the value chain; design health and nutrition interventions that contribute to the productivity of agricultural labour; look carefully at the downstream effects of production or consumption subsidies on consumers' nutrition and health.
- *Seek out and scale up innovative solutions.* Scale up successful interventions; design agriculture, nutrition and health programmes with cross-sectoral benefits; incorporate nutrition into value chains for food products; use all available levers for change; increase consumers' nutrition literacy and highlight the consequences of dietary choices.
- *Create an environment in which cooperation can thrive.* Focus on partnerships among agriculture, nutrition and health; develop mutual accountability mechanisms among the three sectors; correct market failures; use communication and advocacy to bring about change.

Source: Fan & Pandya-Lorch, 2012 (18).

Case study 9.2 *Nutrition-sensitive development in Malawi: bridging sector-wide approaches*

Ruth Butao

Despite slow improvement, especially within the last decade, Malawi continues to suffer from one of the highest stunting rates in the world: almost 50% of Malawian children are affected by low height-for-age. Mortality rates are high among infants and children under five years old; during pregnancy; and during childbirth. Although a greater variety of foods is potentially available, staple crops (especially rainfed maize) make up over half of the total energy in most people's diet. The fact that stunting rates in Malawi are higher than in neighbouring countries with equal per-capita incomes suggests that such malnutrition cannot be attributed to poverty alone. Instead, poor feeding practices for neonates, infants and young children; a generally high disease burden, including HIV/AIDS; and limited

Case study 9.2 *contd*
access to safe, nutritious and diverse foods are the main factors hindering Malawi's progress towards MDG1.

In the past, Malawi's government has expressed a strong political will to fight malnutrition, declaring nutrition-sensitive development an explicit priority in the country's overarching medium-term policy framework. The country also benefited from a charismatic nutrition champion: Dr Mary Shawa acted as Secretary for Nutrition, HIV and AIDS until deployed to the Ministry of Gender, Children and Community Development in early 2012. Malawi was among the first countries to join the SUN initiative and to endorse the SUN Framework under which both government and donors committed more resources to nutrition. In addition, the Department of Nutrition, HIV and AIDS (DNHA) was positioned within the Office of the President and Cabinet, giving it high visibility and creating the political environment for an integrated approach to nutrition. As a high-level coordinating authority, the DNHA provides policy and technical guidance and supports resource mobilization on nutrition. Subsequent to the IFPRI-hosted conference: Leveraging Agriculture for Nutrition and Health held in New Delhi in early 2011, Malawi held a follow-up national event to develop a comprehensive strategic framework. This successfully translated high-level political commitment into concrete plans for action at lower levels.

The two main strategies to ensure an integrated approach to nutrition in Malawi include: (i) establishing the DNHA as a high-level national coordination mechanism for integrating nutrition-sensitive development into the work of a series of ministries (e.g. Health; Agriculture and Food Security; Gender, Children and Community Development; Education, Science and Technology); and (ii) requesting and fostering close communication and collaboration between different Sector-Wide Approach programmes (SWAps). Whereas the general advantage of SWAps is usually seen in better linking stakeholders *within* the sector, little attention is often paid to ensuring linkages *between* sectors. Malawi's efforts to ensure collaboration between sectors include the creation of a number of committees with representatives from the different sectors. To date, four of Malawi's SWAps (Agriculture; Health; Education and Gender; Youth Development) have integrated nutrition security into their respective frameworks by including specific objectives and activities as well as budgets for nutrition.

The national conference: Unleashing Agriculture's Potential for Improved Nutrition and Health in Malawi (2011), made recommendations for improving collaboration between the health and agriculture sectors. The

Case study 9.2 *contd*
most prominent include: (i) establishment of a common framework to integrate nutrition across the Ministry of Agriculture, Irrigation and Water Development, the Ministry of Health and the DNHA; (ii) improved advocacy for nutrition at community level; and (iii) building on best practices (also looking at indigenous knowledge and community initiatives) and exploring opportunities for their scaling-up.

Case study 9.3 *Towards a comprehensive and coherent food and nutrition security policy for Afghanistan*

Andreas Groetschel

Afghanistan has some of the worst food security and nutrition indicators in the world. Production patterns based on subsistence farming; overall low productivity; and high poverty incidences in both urban and rural areas leave two thirds of the population in, or at least vulnerable to, food insecurity. Children and women are most affected.

Approaches to address issues of nutrition and food security vary, are spread over different ministries and supported by several development partners. Problems and projects are discussed in different technical working groups (clusters) for nutrition and for food security, with participation mainly from United Nations' partners and NGOs. Within government institutions many staff struggle with the concepts and technical issues. At the same time, the responsibilities for food and nutrition security are unclear within the individual ministerial mandates. Government coordination has been weak and is not yet well institutionalized.

Collaboration at field level is based mostly on informal (personal) relations. Agencies and individuals in provinces and districts know each other and so, although usually not based on institutionalized cooperation, joint activities form an important base from which to learn and derive lessons for policy decisions at national level, both within government and between development partners.

Unfortunately, awareness-raising, training and capacity-building efforts (particularly at provincial or district level outside Kabul and the provincial capitals) are hampered by the prevailing security situation. This affects not only the operations of development partners but also government staff who face difficulties travelling. This situation is further exacerbated by cultural difficulties and constraints for female staff working and travelling outside their home communities.

Case study 9.3 *contd*

The Ministry of Public Health recently developed a National Public Nutrition Policy and Strategy 2010–2013. Operationalization has been supported by a World Bank initiative to elaborate a nutrition action framework with action plans for individual ministries. The Ministry of Agriculture, Irrigation and Livestock has formulated a national priority programme (Food for Life) to address food and nutrition security issues that fall under its mandate. At the same time, the World Food Programme and the Food and Agriculture Organization of the United Nations (FAO) have assisted the Afghan Government to elaborate a comprehensive food and nutrition security (FNS) policy for Afghanistan. Each of these three initiatives was started independently, under different leadership and with the support of different partners.

Recognizing: (a) institutional cooperation difficulties at interministerial level; (b) potential synergies between preventive, curative and food-based approaches; and (c) the need for a single high-level guiding and coordinating body, all involved partners are now merging their activities under the umbrella of an FNS policy. This is driven by the institutional leadership of the Vice-President's Office and its attached FNS Technical Secretariat. The overall goal is a coherent and coordinated approach to reduce food and nutrition insecurity and to strengthen the Afghan Government's leadership in this field. This will not completely compensate for the need for, and ongoing efforts in, decentralized awareness raising and capacity building. However, it is expected to increase government ownership, promoting a more inclusive approach that builds on state institutions that – while still fragile – are still more sustainable than those of external partners.

The ingredients and processes needed to make policies more nutrition sensitive are well-known but many governments still face challenges in making nutrition security an integral part of national policies (19). General guiding principles (see Box 9.3) that are globally applicable to different national contexts can support governments to set a frame for nutrition-sensitive agriculture policy and help overcome the challenges of tackling the highly complex task of engaging multiple players to work on an intersectoral issue.

9.5 Conclusion

Food and agriculture policies clearly have a major role to play in improving nutrition and health and in reducing poverty. But a better understanding of the linkages between agriculture, nutrition and health is required in order to fulfil this role.

Box 9.3 *Guiding principles for nutrition sensitive agriculture policy*

Nutrition sensitive agriculture policy:

1. increases incentives/reduces disincentives for production of nutrient-dense foods;
2. increases incentives/reduces disincentives for production diversification;
3. increases incentives/reduces disincentives for environmentally sustainable production;
4. invests in research to increase productivity of nutrient-dense foods in low-resource conditions and diverse systems;
5. invests in higher education that trains future leaders on agriculture-nutrition linkages;
6. builds capacity among ministry staff and extension workers to understand linkages and communicate relevant behaviour-change information;
7. improves gender equity in extension and training;
8. provides nutrition information about foods and diets, through schools, higher education and markets;
9. improves smallholders' access to government-controlled markets such as food aid/social protection, communal catering (e.g. school lunch programmes, hospitals and workplace canteens);
10. improves infrastructure needed to provide market access for smallholders and other vulnerable groups, improves access to market price information, avoids trade policies that would preclude smallholders' market access;
11. builds resilience against shocks through infrastructure and social safety-net programmes;
12. has institutional mechanisms and incentives to coordinate with other sectors relevant to nutrition (e.g. health, social protection, education).

Source: Adapted from FAO 2013 (20).

Classically developed at global and national level, food and agriculture policies have been formulated using a macro approach to increasing food availability: focusing on supplying commodities (particularly cereals) at an aggregate level through improved food production, effective value chains and international trade. Little, if any, attention has been paid to healthy diets, social equity and environmental impact. The needs of the poor are often neglected and thus agriculture fails to ensure nutrition security. Distortions, increased vulnerability and more frequent food crises result from disconnects between food production and supply on the one hand, and consumption and demand on the other.

New challenges that need to be addressed have emerged in recent years. More than half the world's population now lives in urban areas and globalization has led to an unprecedented dietary transition, yet urban-rural linkages have been neglected. Food systems need re-orienting to benefit both urban consumers

and rural producers. Food price volatility affects both producers and consumers and is compounded by and, to some extent, fuels recurrent economic crises. Environmental degradation, loss of biodiversity, water scarcity and climate change exacerbate the fragility of food systems. Short-term responses to emerging crises remain disconnected from necessary structural solutions.

Malnutrition can be addressed sustainably only if more systemic approaches are developed. Consensus is finally growing on the need for resilient food systems and incorporation of health, equity and environmental concerns. Local approaches are usually the most effective entry point to address complexity, inform sustainable development policies and empower people and institutions. Nutritional and health status can be improved by building upon local knowledge and experience, seizing opportunities and addressing constraints. Safe, sustainable and healthy diets are compatible with sustainable management of natural resources and social equity.

Gender equity is of paramount importance. Indeed, adoption of a comprehensive gender-progressive approach to fostering convergence between agriculture and nutrition is a likely win–win. Options and approaches are needed for empowering women to participate actively in decision-making, particularly on food consumption and the choice of agricultural products to be produced and/or purchased by the household. If a feminization of agricultural labour is increasingly matched with a feminization of control over households' resources and decisions – and so long as women's own nutritional status is protected – child undernutrition rates will decline.

Intersectoral collaboration is essential if agriculture is to become more nutrition sensitive or 'pro-nutrition'. This will require changes to: the way that food and nutrition-relevant institutions operate; incentives; and modes of planning, strategy development, implementation, monitoring and evaluation. Greater priority should be attached to generating actionable knowledge at local levels, and to impact assessment in general. Nutrition-relevant indicators need to be built routinely into agricultural monitoring and evaluation systems to increase the visibility of agriculture-nutrition links and to strengthen accountability and responsiveness among a wider group of actors. Better nutrition and healthier agriculture are mutually reinforcing goals that will require even greater prominence as we move towards a post-MDG world.

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Chapter 10
Tobacco or health

Douglas Bettcher[1]*, Vera Luiza da Costa e Silva*

Key messages

- Tobacco control programmes are an integral part of the public health agenda, with proven cost-effective measures and 'best buys' for implementation.
- Tobacco control programmes are an example of 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.
- Cost-effective policies for curbing the tobacco epidemic include taxes and price increases; smoke-free public places; smoking cessation; tobacco advertising, promotion and sponsorship (TAPS) bans; education on the health consequences of tobacco use; package health warnings; and efforts to combat illicit trade. These are more effective when implemented comprehensively.
- Experiences worldwide point to the need to establish a national coordination mechanism with wider stakeholder participation (both within and outside government) in order to achieve the best results.
- The huge (and sometimes undocumented) health and environmental costs of tobacco use, and the socioeconomic benefits of tobacco control, show that tobacco control programmes must be set within governments' broader development agendas, and within other programmes of sustainable development.
- Preventing and counteracting the tobacco industry's undue interference in public health (including existing pro-tobacco intersectoral action against health) is a growing concern for governments and civil society.

1 The views expressed in this chapter do not necessarily reflect the views of the World Health Organization

- Areas of further research include forms of smoking tobacco other than cigarettes and chewing tobacco.
- Tobacco control provides examples of policies, regulations and implementation practices that can guide risk factor control programmes for other NCDs.

10.1 Introduction

Tobacco is the most widely available harmful product on the market – more than 1 billion tobacco related deaths are projected for the twenty-first century, especially afflicting low- and middle-income countries (LMICs) (1, 2). Globally, 12% of all deaths among adults aged 30 years and over were attributed to tobacco use (5% from communicable diseases; 14% of NCDS) (3). The highest proportions occur in WHO Regions of the Americas and Europe, reflecting higher exposure for a longer period of time (Table 10.1).

Table 10.1 *Proportions of all deaths attributable to tobacco, 2004*

WHO Region	Proportion of all deaths attributable to tobacco (%)		
	Men	Women	All adults
African	5	1	3
Americas	17	15	16
Eastern Mediterranean	12	2	7
European	25	7	16
South-East Asia	14	5	10
Western Pacific	14	11	13
Global	16	7	12

Source: WHO, 2012 (3).

Commercial cigarettes are the most commonly used type of smoked tobacco. Consumption of bidis, kreteks, shisha[2] and smokeless tobacco is increasing around the world, with associated risks (4, 5).

Tobacco use harms men and (increasingly) women, particularly during their reproductive lifetimes (6). With smoking rates nearly five times those of women, men have higher global rates of tobacco use and tobacco-attributable mortality (3). But it is particularly concerning that smoking rates are accelerating among women. Worldwide smoking rates among boys and girls are closer than smoking rates among adult women and men: among 13–15 year olds, boys' smoking rates are only two to three times higher than those of girls (7). Nevertheless, this seems to reflect not health awareness but rather social traditions and women's

2 Bidis: small, hand-rolled cigarettes typically smoked in India and other South-East Asia Region countries; kreteks: clove and tobacco cigarettes most commonly smoked in Indonesia; shisha: tobacco cured with flavourings and smoked from hookahs or narguiles, primarily in the Eastern Mediterranean Region.

low economic resources (8). Second-hand smoke also harms others, including non-smokers, and increases the burden of diseases attributable to tobacco use.

Tobacco use is associated with poverty: poor people smoke more and money spent on tobacco can consume a substantial proportion of total household income. Smoking-related expenses seem to have pushed a significant proportion of low-income families into poverty in China (9). Tobacco product consumption is increasing in the developing world and now surpasses that of many industrialized countries where, in general, it is steadily but slowly decreasing (1).

Tobacco use is a prime example of the perverse effects of the globalization of risk factors. The transnational tobacco corporations use marketing, trade, research and industry influence to increase their profits and the returns enjoyed by shareholders, at the formidable expense of public health worldwide (10). Furthermore, a substantial proportion of the profits generated by the tobacco industry flows back to their national base, representing a transfer of wealth from one region of the world to another (11). The global strategies of the tobacco industry are increasingly reaching LMICs where tobacco and poverty create an additional burden for the health and well-being of low-income populations and there is weaker capacity to counteract tobacco industry strategies and regulate tobacco products (12).

10.2 Historical perspective and policy tools to curb tobacco consumption

10.2.1 What moves the tobacco control agenda

Tobacco control history shows that political decisions have been key in advancing tobacco control around the world as a result of evidence-gathering, regulation, information, financial support and networking.

Evidence-based research from academia was crucial in pushing tobacco control actions: by generating data, information and awareness and by providing the bases for establishing policy framework and responses. Doll and Hill's groundbreaking case-control study in the 1950s established the first causal evidences between smoking and lung cancer. In addition, the authors' subsequent prospective study is considered to have marked the beginning of modern epidemiology (13), showing an important shift in the focus of epidemiological research from infectious to chronic diseases (14). These studies have been followed by hundreds of thousands of studies in different populations and countries, establishing causal relationships as well as cost-effective measures with estimates of their impact on the tobacco epidemic.

This was potentiated by the initiative of many governments that have assembled existing evidence and policy options to raise awareness of the tobacco epidemic and have promoted the implementation of cost-effective measures. Since 1964, the US Surgeon General's comprehensive reports on smoking and health addressing tobacco-related topics have alerted the world to the health risk of smoking, transforming the issue from one of individual/consumer choice to one of epidemiology, public health and risk for both smokers and non-smokers (15). Practical examples from countries that passed legislation around the mid 1970s (e.g. Norway, Finland) have shown that the implementation of tobacco control measures was possible, feasible and urgent. Governments such as those of Canada (16), Australia (17) and the EU (18), have further released blueprints on tobacco or health to move their national tobacco control agendas. Government initiatives led to the release of a number of tobacco industry internal documents under the Master Settlement Agreement. Signed between the attorneys general of 46 states of the United States of America and the country's 4 largest tobacco companies (19), this shed light on industry strategies to mislead the public and public opinion.

Intergovernmental organizations played a key role in pushing the tobacco control agenda. The 1979 report of the influential WHO Expert Committee on Smoking Control pioneered the concept of an international instrument to control the epidemic. Using WHO's constitutional authority, a number of WHA resolutions and annual awareness raising campaigns commemorated globally through World No Tobacco Day every 31 May (20) have promoted tobacco control as a public health problem and boosted many national initiatives (21). The World Bank publication *Curbing the Epidemic* was also highly strategic in addressing the economic argument raising the need for non-health sectors to be involved in tobacco control by the late 1990s; it also established the evidence-base for WHO FCTC negotiations (22).

Civil society assumed the advocacy role claiming that governments, academia and NGOs bore joint responsibility to counter the tobacco epidemic. Since 1967, World Conferences on Tobacco or Health (WCTOHs) have been key for exchanging information, discussing trends and recommending new measures (23). The WCTOH in Paris in 1994 recommended that WHO should propose beginning negotiations on the WHO FCTC with Member States. Several civil society players were organized under the umbrella of the Framework Convention Alliance in order to negotiate and further implement the WHO FCTC.

An evidence-based treaty, the WHO FCTC (24) established an international regulatory mechanism involving demand and supply reduction strategies. This aimed to address the ineffectiveness of country efforts to halt the global tobacco epidemic by the end of the twentieth century, and to react to the expansion of

the tobacco industry's aggressive marketing in the developing world. The treaty was adopted in 2003 and entered into force in 2005 (Box 10.1) (25).

Box 10.1 *WHO FCTC: core structure*

Core demand reduction measures (Articles 6–14):

- price and tax measures to reduce the demand for tobacco
- protection from exposure to tobacco smoke
- regulation of the contents of tobacco products
- regulation of tobacco product disclosures[1]
- packaging and labelling of tobacco products
- education, communication, training and public awareness
- tobacco advertising, promotion and sponsorship
- concerning tobacco dependence and cessation

Core supply reduction measures (Articles 15–17):

- eliminating illicit trade in tobacco products[2]
- prohibiting sales to, and by, minors[3]
- provision of support for economically viable alternative[4] activities.

The WHO FCTC also covers other important areas including liability; protecting public health policies concerning tobacco control from the interests of the tobacco industry; environment protection; national coordinating mechanisms; international cooperation, reporting and exchange of information; and institutional arrangements (Articles 5 and 18–26).

1 Information on tobacco products disclosed as governmental and public information: (i) measures requiring manufacturers and importers of tobacco products to disclose to governmental authorities information about the contents and emissions of tobacco products; (ii) measures for public disclosure of information about the toxic constituents of the tobacco products and the emissions that they may produce.
2 Elimination of all forms of illicit trade in tobacco products, including smuggling, illicit manufacturing and counterfeiting.
3 Measures at the appropriate government level to prohibit the sales of tobacco products to persons under the age set by domestic law, national law or under 18 years.
4 Economically viable alternatives for tobacco workers, growers and, as the case may be, individual sellers.

As the first global health treaty negotiated under the auspices of WHO, the WHO FCTC has brought a new legal dimension to international health cooperation, setting out a general framework for subsequent guidelines and protocols. Several key guidelines have already been adopted (26). The fifth session of the Conference of the Parties to the WHO FCTC (*COP5*) recently adopted the first protocol to the Convention, aimed at combating the illicit tobacco trade (27). The WHO FCTC is a good example of a global agreement that addresses an important NCD risk factor and ultimately promotes health. Its strategies and policies, as well as its multilateral framework, have been proposed for controlling obesity and could be considered for other health promotion initiatives (28).

In addition to political decisions, funding of tobacco control activities is a major determinant of policy implementation. Many countries have competing priorities that prevent the allocation of substantial funds. In the last 20 years, global funds for tobacco control have therefore created opportunities at international, regional and country level. Examples include the United Nations Foundation support for WHO's (then) recently established Tobacco Free Initiative, increasing preparedness for the negotiations of the WHO FCTC (21); Bloomberg Philanthropies (29, 30) and the Bill & Melinda Gates Foundation (31). Funds for tobacco control are increasing at country level but are still not sufficient to face the tobacco epidemic. Each year, governments collect a total of nearly US$ 133 billion in tobacco excise tax revenues but spend less than US$ 1 billion on tobacco control, 97% of which is spent by high-income countries. Positive experiences in using earmarked taxes to fund health promotion and tobacco control activities have been described in many countries (e.g. Thailand) (32), see also Chapter 5).

10.2.2 The international landscape

A growing body of evidence suggests a link between increased tobacco consumption and free trade and tobacco-related foreign direct investment. The threat to public health posed by the global tobacco market is likely to increase as a result of the global trend towards greater liberalization of trade and foreign direct investment. This threat is exacerbated by transnational tobacco company strategies to enter emerging-market economies, and by new cross-border challenges such as Internet commerce and illicit trade of tobacco products (33). Globalization has assisted the tobacco industry and its allies in promoting the tobacco epidemic in the developing world: for example, by using international trade agreements to prioritize corporate rights over the right to health by eliminating barriers to tobacco importation and restrictions on advertising (34). Transnational tobacco companies have recently challenged tobacco control measures in Australia, Norway, Turkey and Uruguay – not only through national courts of justice, but also by using international bilateral investment agreements and the WTO dispute settlement mechanism to protect corporate interests (see Chapter 5).

The tobacco control experience can serve as an example for the wider health sector. The public health community must gain an understanding of the health effects of global trade agreements. 'Healthy trade' policies based on firm empirical evidence and designed to improve health status are an important step toward reaching a more sustainable form of trade liberalization (35). Currently, the international landscape is favourable for the implementation of tobacco control interventions. The United Nations High-level Meeting

on the Prevention and Control of Non-communicable Diseases brought together WHO Member States to agree the declaration on NCDs, amongst other things calling on existing Parties to accelerate the implementation of the WHO FCTC, and other Member States to accede to the treaty (36). There have been many calls to include tobacco control within the MDGs (37) and inclusion of tobacco control as either a model or part of further agreements is being considered in many other relevant policy-setting instruments.

International and national tobacco control landscapes have been changing as countries make progress in curbing the epidemic. Challenges and emerging issues include testing and regulating tobacco products aiming at harm reduction and risk reduction; denormalizing the tobacco industry and reducing its social influence (38); viewing human rights as a mandatory corollary to tobacco control (39); addressing social determinants as a major element to curb the tobacco epidemic (34); and, last but not least, responding to the different challenges of tobacco agriculture. The latter requires not only consideration of tobacco growers' health and human rights but also crop diversification as a step towards replacement (see Chapter 9 for a related discussion). Fig.10.1 highlights the key global tobacco control events described in the text.

Fig. 10.1 *Key events in tobacco control history*

1950	First epidemiological studies
1967	First World Conference on Tobacco or Health
1970	First WHO resolution on tobacco control | WHA23.32
1988	WHO World No Tobacco Day commemorations begin | WHA40.38 and WHA42.19
1998	Master Settlement Agreement in the USA
1999	World Bank Curbing the Epidemic
	United Nations Foundation/United Nations Funds for International Partnerships' funding for tobacco control
	WHO FCTC negotiations begin
2003	WHA adopts WHO FCTC
	Civil society formally organized under the Framework Convention Alliance
2005	WHO FCTC enters into force
2006	Funding from philanthropies boosts tobacco control in the developing world
2007	Start of Protocol to Eliminate Illicit Trade in Tobacco Products negotiations
2012	COP5 adopts Protocol to Eliminate Illicit Trade in Tobacco Products

10.3 Countries' challenges in addressing the epidemic: the politics of tobacco control

In order to curb the tobacco epidemic by means of established evidence-base interventions already tested in some countries, and in compliance with the WHO FCTC, most countries have initiated or strengthened tobacco control activities by deciding on a number of policies to implement. Many specific aspects of countries' political, social and economic landscapes can be explored as determinants of their decisions on where to start and what to prioritize. Health priorities determine the emphasis on tobacco control, including how the primary health-care system is organized, health-care providers are properly trained and treatment is made available. Tobacco control might not be seen as a priority in countries were the epidemic is still in the initial phase but infectious diseases are highly prevalent. Similarly, pressing legislation can displace tobacco control measures in government priorities.

Countries also face economic challenges from the tobacco business in the national context, a legal product that permeates all levels of political decision. This can be related to the presence of a state-owned or multinational tobacco company, or both. This is true everywhere – even in developed countries such as Australia, Canada, Japan or Sweden – where the presence and strong lobby of the tobacco industry is considered to have posed challenges to implementation (40–42). Tobacco growing countries can also face a challenging political scenario from claims that tobacco control would affect livelihood in the agricultural sector. This is the case of countries such as Brazil and Turkey (43, 44). Nevertheless, by facing these challenges upfront by prioritizing alternative livelihoods or policies that consider opportunities for vulnerable populations of tobacco growers, these countries strengthen not only their tobacco control agenda but also their social agenda (see Chapter 9).

Whether in developing or developed countries, in the northern or southern hemisphere, awareness raising and dissemination of information is key to building social support for tobacco control policies. Targeted information should be shaped in order to consider diverse populations (e.g. urban and rural) and to reflect socioeconomic inequalities and social determinants for health.

Policy decisions can also be affected by adherence to international legal instruments. Currently, 176 of 194 WHO Member States are Parties to the WHO FCTC (not including the EU)[3] (25). Being a Party to the treaty is in itself more then a strong motivator to move the tobacco control agenda and a legal obligation that makes it a priority to implement their provisions. In one recent example, a South African court used the country's status as a Party to

3 The EU is a Party to the WHO FCTC as an economic integration organization.

WHO FCTC as the basis for ruling in favour of public health (45). This shows how a domesticated legally binding treaty can be an extremely effective tool for moving the tobacco control agenda. Nevertheless, it would be wrong to conclude that Member States who are not Parties must therefore have political environments that prevent the implementation of tobacco control measures. Most non-Parties have made important progress in controlling the epidemic. For example, Argentina recently passed comprehensive legislation; and the United States of America has not only seen recent sound national developments but plays a remarkable role in global tobacco control. However, by becoming Parties to the treaty, countries sit within the international framework of technical and financial cooperation and contribute to the negotiations of protocols, guidelines and recommendations. This is especially helpful in provisions that have cross-border effects and provides benefits not only to their own population but to those of other countries.

10.4 Implementation of tobacco control policies

There is an abundance of evidence-based interventions for tobacco control, many of which have been published extensively in peer review literature in the last decade. Every country has a menu of options that can be selected and implemented according to national priorities and there are many examples showing how research has pushed policies at this level. Ireland, New Zealand, Norway and Uganda were among the first countries in the world to implement smoke-free policies based on research conclusions that second-hand smoke threatens people's health and can be controlled only through complete bans on smoking in public places (32).

A number of approaches and practices in tobacco control are typically used in programme implementation at country level. Some are proven to be essential for any public health programme: supporting management, monitoring and evaluation activities, and addressing the multifaceted aspects of tobacco control.

Tobacco control programmes require consideration of several key ingredients.

Multisectorality

Virtually all countries that have implemented successful tobacco control programmes (26) have involved multiple partners and sectors. In order to address legal issues – as well as economic, marketing and environmental aspects – tobacco control interventions should go beyond well-known public health measures, especially where the health sector lacks knowledge, mandate or experience. Lawyers, economists, agronomists, teachers, psychologists, communicators and social workers, among others, are essential to advance the

tobacco control agenda in their respective areas of work. Government players and civil society have well-defined roles. They can also form partnerships with the private or non-profit-making/nongovernmental sectors provided there is a firewall against the vested interests of the tobacco industry and its front groups. Civil society involvement is central to achieving effective legislation and implementation of tobacco control measures.

Comprehensiveness, with concerted actions among different stakeholders

Often, tobacco control programmes are focused on preventing initiation of smoking among youths and young adults; promoting cessation among all smokers; reducing exposure to passive tobacco smoke; and regulating tobacco products to reduce exposure and consequent harm. Some countries have included identifying and eliminating disparities among population subgroups as one additional pillar in tobacco control (46). Identifying the precise pattern of inequity in tobacco use among different income groups and addressing social determinants of health are some of the aspects that must be pursued. Overall, key tobacco control interventions are usually implemented in parallel, and should also crosscut with the health promotion agenda. Recent analyses clearly indicate that such comprehensive efforts have successfully reduced tobacco use (46).

Country capacity: infrastructure, human resources and administration

Country capacity includes availability of the political commitment and organizational structure required to implement the most effective tobacco control policies (47). It comprises partnerships (within government and between government and other interested parties); human and financial resources and needs; and the technical, managerial and political processes that are vital for implementing policies effectively. A national plan of action is usually an integral part of a tobacco control programme, officially approved by the competent authorities and agreed by all stakeholders involved. An intersectoral body (e.g. national commission, steering committee) guarantees coordination and participation in decisions on policies and procedures among different sectors of the society. But the infrastructure is not only physical, it also includes human resources to guarantee adequate staffing and management; access to decision-makers and regular funding sources that are essential in the context of countries' obligations under the WHO FCTC (24).

Surveillance and monitoring system

Accurate measurement is vital to understand the problems caused by tobacco and ensure effective management and improvement of interventions (48, see also Chapter 6). Defined mechanisms to monitor tobacco control measures,

the tobacco epidemic and the activities of the tobacco industry are necessary but often missing in tobacco control programmes. Many national initiatives are in place in order to monitor progress in tobacco control, especially in countries that possess health surveillance systems that incorporate tobacco use and control as a variable. The Global Tobacco Surveillance System (49) is currently housed in WHO. Countries' decision-making has also been supported by other international surveillance systems such as the International Tobacco Control Policy Evaluation Project (50) and the World Bank studies on countries' tobacco economic analysis (51). WHO's regular evidence-based reports on the status of the tobacco epidemic have revolutionized identification of best practices in tobacco control and of country trends in reducing demand for tobacco (4, 6, 32).

Implementation, enforcement and compliance mechanisms of laws

Government has a central role in ensuring that rules are implemented and complied with. Voluntary and market-based compliance approaches that encourage and assist change are generally discouraged when drawing up and implementing tobacco control law as the tobacco industry frequently uses them to avoid strong regulation (52). The enforceability of tobacco control requirements ultimately determines the effectiveness of the laws and the degree of compliance. Therefore, in order to be effective, enforcement strategies must have an adequate legal mechanism and designated authorities. Furthermore, unclear, imprecise, ambiguous, inconsistent or contradictory tobacco control requirements may present a bottleneck to enforcement. Adequate infrastructures and training of inspectors and enforcement officials are essential.

Anticipating and responding to tobacco industry opposition

The tobacco industry includes national or transnational groups with private, state-owned or mixed management and third party allies promoting tobacco industry interests which are mobilized to obstruct, change or delay policies. Worldwide evidence demonstrates that the industry has undertaken coordinated concerted efforts to interfere with tobacco control, therefore mechanisms to monitor and respond to such opposition are crucial. The COP has adopted guidelines to orient implementation of article 5.3. These were based on the best available scientific evidence and the needs identified by all countries, regardless of tobacco industry ownership or the structure of tobacco control programmes (26).

Opposing intersectoral action against health

HiAP and intersectoral action is not just a linear process. Tobacco control proves that counteracting/countervailing intersectoral forces can oppose health

promotion and health sustaining efforts. This includes groups that speak on behalf of and serve the interests of the tobacco industry (53). While sometimes unaware that they are promoting tobacco industry interests, their role is very much linked to specific measures announced or identified by government. They include (but are not limited to) hospitality, gambling and gaming, advertising, packaging, transport, chemical production, tobacco retailing, agriculture and tobacco growers, labour unions and investment advisers. Other potential allies include recipients of tobacco sponsorship and research funds. The tobacco industry has been quite successful in mobilizing these groups in an articulated way in order to create a true intersectoral framework against evolving public health efforts to curb the epidemic. Australia and Uruguay provide examples of investment and trade alliances working against public health measures (54). Nevertheless, national trade and health sectors in Australia are aligned to support the revolutionary law on plain packaging (see Chapter 11 for a related discussion).

Case study 10.1 illustrates how the governance aspects of tobacco control can vary in accordance with a country's characteristics. Brazil consolidated a solid tobacco control programme despite strong lobbying from the tobacco industry and many challenges from competing priorities. By designing a

Case study 10.1 *Brazil: successes and challenges in tobacco control*

The polarity of being both a major global tobacco producer and the international leader in tobacco control (21) ultimately illustrates how public health concerns can take priority on the government agenda of a tobacco-growing developing country. Tobacco use prevalence among adults in Brazil was 34.8% in 1989, with important impacts on tobacco-related diseases (56). Following establishment of the National Tobacco Control Programme in 1988, the first national work plan was drafted for the period 1988–2000, with the aim of organizing government action and nongovernmental joint collaboration (57), anticipating the main strategies that the WHO now recommends.

Main developments in this period included the establishment of the Brazilian National Health Surveillance Agency (ANVISA) in 1999. This was granted the mandate to regulate tobacco products, inspect the enforcement of laws that were progressively being enacted and denormalize tobacco use in society. Examples of successful policies include the TAPS ban (since 2000); pictorial health warnings (since 2001); freely available smoking cessation treatment (since 2003); smoke-free places with no restrictions (law in 2011 with possible regulation in 2013); and stepwise tax and price increases (from 2012 to 2015). Decentralized tobacco control programmes operated through

Case study 10.1 *contd*

the Unified Health System (SUS) have reached almost 4000 municipalities since 1985, with capacity building initiatives creating critical mass in the health sector. The National Committee for WHO FCTC negotiation was established as an inter-ministerial group in 1999 with the function of supporting Brazil´s positions in the international treaty making process by advising the President's Cabinet and reducing potential interference from the Brazilian tobacco industry. It was replaced by the National Committee for WHO FCTC Implementation (CONICQ) in 2003. Brazil ratified the WHO FCTC in 2005, despite strong opposition from the tobacco production sector (43).

Established in 2003, the Brazilian Alliance for the Control of Tobacco Use (ACTBR) voiced the public health argument and consolidated civil society's network and participation supporting implementation of the treaty (58). Today, Brazil has a solid tobacco control programme despite the strong tobacco industry lobby and competing priorities that present many challenges. By designing a strategic vision of the problem, creating a management model and including a multidisciplinary and decentralized approach, this programme has became a model of successful public health actions in Brazil. Smoking prevalence decreased to 17.2% in 2008 and the impact on tobacco related diseases has already been reported as a consequence (55). Progress has been far from linear and there are several examples of intersectoral action against health. These include many legal actions brought by the tobacco industry and its allies and many challenges to governance of the tobacco control programme.

One recent example (43) involved a public hearing for a regulatory proposal to ban cigarette additives which has provoked strong opposition from a wide range of organizations that collaborate with the tobacco industry. Labour unions and tobacco growers were mobilized with the argument that tobacco growers' livelihoods would be damaged; trade associations of the retail and hospitality industries were mobilized with the claim that retail outlets would close. A concerted campaign to oppose the proposal was promoted among all these stakeholders through direct communication, e-mails and web sites. The government received almost 258 000 letters opposing the measure. In parallel, the government judiciary was involved in initiatives such as conferences and lectures to promote 'freedom' as an essential element of the free trade of a legal product. Hence, despite progress, much more effort is required to counter the actions of a tobacco industry that is continually seeking new strategies to promote tobacco consumption and subvert public health measures.

strategic vision of the problem, creating a management model and including a multidisciplinary and decentralized approach, the tobacco control programme became an example of best practice for successful public health actions in Brazil. Smoking prevalence has decreased from 34.8% in 1989 to 17.2% in 2008 and the impact on tobacco-related diseases has already been reported as a consequence (55).

10.5 Conclusions: tobacco control as a framework for primary prevention interventions promoting HiAP

The knowledge gained on tobacco control research, policies and programmes over the last few decades demonstrates experiences and lessons that can be useful for the control of other risk factors for NCDs. Programmes targeted to different populations and groups, and permeating multisectoral and multiplayer policies, provide a vast evidence base of success for other interventions. Some political arguments can promote tobacco control as a HiAP component. One important factor used to control the epidemic is *the use of evidence against vested interests*: cigarette smoking is probably the most researched area in epidemiology, and epidemiological investigations of cigarette smoking and lung cancer can be considered a major success of the discipline (59). Studies of the relationship between smoking and health risks have had an important role in establishing the basis of observational epidemiological studies and causal inferences. This methodology has been applied to identifying other risk factors and has proved useful to further understanding the causality of NCDs (60).

Research has also been key in providing evidence of different strategies that the tobacco industry uses to keep business growing at the expense of public health. These include alleging personal responsibility (blaming the smoker); challenging scientific consensus (paying scientists to deliver research casting doubt on the 'junk' science that found harms associated with smoking and second-hand smoke); misleading the public (denying the addictive nature of tobacco products and their marketing to youth); making both international and national self-regulatory pledges; allocating massive resources to lobby against government action; and introducing 'safer' products and manipulating ingredients (61).

Many significant similarities have been identified with the food industry's actions in response to concerns that their products cause harm and stimulate the global obesity problem and in the fuel industry (62, 63). The United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases included reports of other industries using the same strategies as the tobacco industry (64). Intersectoral action against health has also been incorporated

in the marketing strategies of food and alcohol multinational companies (see Chapter 11).

A second important factor is the *use of legal frameworks to curb the epidemic*. The WHO FCTC (24) is a good example of a global agreement that addresses an important NCD risk factor and ultimately promotes health. Strategies and policies contained in the treaty, as well as its multilateral framework, have been proposed for controlling obesity (65) and could be considered for other health promotion initiatives (66) (see Chapter 7 for a related discussion).

Other international agreements, especially those related to trade and investment, have been used to dispute national tobacco control regulations. Recent examples include challenges in the WTO, challenging tobacco control laws through regional and bilateral free trade agreements and disputes under international investment agreements between foreign investors and states. Globalization has also assisted the tobacco industry and its allies to promote the tobacco epidemic in the developing world (67). The public health community must gain an understanding of the health effects of global trade agreements as 'healthy trade' policies based on firm empirical evidence and designed to improve health status are an important step towards a more sustainable form of trade liberalization.

Finally, *common understanding between different sectors* is of outmost importance. Individual approaches using the medical model and traditional public health interventions are inadequate for addressing the tobacco epidemic effectively. Aspects not usually considered within conventional public health practices have been shown to be necessary to control tobacco use. Tobacco is a legal product that is produced, taxed, traded and marketed as part of a commercial cycle. It is also subject to trade agreements and influenced by international rules and government policies. Tobacco control interventions must necessarily address all the different components of the tobacco business. This includes marketing and product regulation, legislation on tobacco use in public places, fiscal policies, sales to and by minors, and litigation and agricultural policies including control of environmental damages. Tobacco is a unique product – killing up to half of its users when consumed as recommended by manufacturers. However, it has been acknowledged that tobacco control can provide lessons about issues such as advertising bans, pricing regulation and health warnings. These best practices can be useful for addressing other risk factors for products that are legally on the market and used by consumers (e.g. alcohol) or components of such products, including food and other goods (e.g. salt) (68). Many countries have invested in a multisectoral approach to tobacco control based on evidence against vested interests and taking advantage of the establishment of legal frameworks. WHO's recent capacity assessment missions (69) provide a glimpse of how

countries such as Brazil, Kenya, Norway, the Philippines, Poland, South Africa, Thailand, Turkey, Uganda and Viet Nam can engage in such exercises for the benefit of public health, engaging in an evaluation of their successes, setbacks and future demands for tobacco control, as parties to the WHO FCTC.

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Chapter 11
Alcohol

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Key messages

- Alcohol is the world's fifth most important risk factor for ill-health and premature death, after high blood pressure, tobacco use (including second-hand smoking), household air pollution from solid fuels, and diets low in fruits.
- Best buys to reduce the harm done by alcohol are price increases, limits on availability and bans on advertising. Jurisdictions with high levels of unrecorded consumption should focus efforts on bringing informal and illicit markets under effective government control.
- Specific intervention strategies should not be implemented in isolation, but rather combined to maximize possible health gains up to the point where it remains affordable to do so.
- The goal of alcohol policy is to reduce the harm done by alcohol. The fact that annual alcohol-related deaths increased by over one third between 1990 and 2010 would suggest that alcohol policy to date is failing.
- Many actions could make a difference – it is important to establish better regulation of the alcohol industry which is currently unable to regulate itself and appears to act with impunity.
- Five main recommendations for the way forward:
    i. governments should recognize that their paramount concern should be the health of their citizens and be active in reducing the harm caused by alcohol;
    ii. governments must implement the best buys for alcohol policy, recognizing that healthy solutions for alcohol are not necessarily costly solutions;

iii. governments must effectively regulate the alcohol industry;

iv. NGOs need to step up their activities as watchdogs and voices for effective alcohol policy; and

v. an international health policy in the form of a framework convention for alcohol control is urgently needed.

11.1 Introduction

This chapter considers alcohol, reaching the main conclusion that there is a dissonance between the size of the problem caused by alcohol and the existing policy response. It has been shown that alcohol was the world's fifth most important risk factor for DALYs (a composite measure of years lived with disability and years of life lost from premature death) in 2010 (1). Alcohol also carries enormous social costs through causing harm to people other than the drinker; impairing personal security and human capital formation; and diminishing educational achievement, employability and productivity (2).

The lack of an effective policy response is illustrated by the increase in the size of the problem over the last 20 years. Alcohol-related deaths increased by over one third between 1990 and 2010: from 2 million to 2.7 million (1). Over the same period, DALYs lost due to alcohol increased by 37%, moving alcohol from eighth to fifth position in the global league table. These estimates underestimate the real burden since they do not account for all forms of alcohol-use disorders and all alcohol-related infectious diseases. Alcohol remains the only consumed drug outside of an international treaty and is paid scant attention by many international bodies (including health bodies) and many governments around the world (3).

Among many reasons for dissonance between the size of the problem and the policy response, three stand out. Firstly, the knowledge gap about the risks of alcohol: many consumers are informed that alcohol is good for health and that it is quite safe to have three drinks (30g alcohol) per day (4). In fact, for most conditions that are negatively related to alcohol (e.g. cancer) (5) there is no level of consumption without risk (6). Secondly, too often effective policy is not implemented because of too close a relationship between the alcohol industry and government officials (7). This policy gap is found all over the world, including in many emerging economies and in low-income countries in Africa (8). Thirdly, a governance gap seen in competing alcohol-related policies across different sectors and departments. At country level and globally these are not aligned to promote health and well-being (9).

This chapter presents a discussion of alcohol's harmful effects on the world's health and well-being; the evidence for effective policies to reduce the harm; a brief assessment of the response to date; and a consideration of what needs to be done to make a difference. We conclude with five recommendations that should be implemented to reduce the harm done by alcohol.

11.2 Harm caused by alcohol worldwide

1. It is estimated that 2.7 million deaths worldwide in 2010 were due to alcohol, increasing from 2 million in 1990. It is estimated that alcohol is the world's fifth principal cause of disability and premature death in 2010.
2. Social costs of alcohol reach some US$PPP 300–400 per individual citizen per year.
3. Economic crises increase alcohol-related deaths.
4. Poorer people suffer more harm per gram of alcohol consumed than richer people.
5. As GDP increases, there are increases in both the proportion of people who drink and levels of per capita alcohol consumption, at least up to a GDP of US$PPP 10 000.

Note: PPP – purchasing power parity.

Alcohol consumption

For the individual drinker, and for societies as a whole, harm results from how much alcohol is drunk on average over a lifetime and, in particular, on any drinking occasion (6). These harms affect the whole lifespan and also impact on people other than the drinker. Alcohol and (particularly) heavy drinking diminish personal security and impair human capital formation, educational achievement, employment prospects and productivity (10).

Box 11.1 *Major health outcomes causally affected by alcohol*

Communicable diseases: tuberculosis; lower respiratory infections.

NCDs: cancers of the oesophagus, mouth, nasopharynx, other part of pharynx and oropharynx, liver, larynx, breast, colon and rectum; alcohol-use disorders; fetal alcohol syndrome; epilepsy; diabetes mellitus;* ischaemic heart disease;* ischaemic stroke;* haemorrhagic and other non-ischaemic stroke; hypertensive heart disease; atrial fibrillation and flutter; cirrhosis of the liver; pancreatitis.

Injuries: transport injuries; injuries from falls, drowning, fire, heat and hot substances, poisonings, exposure to mechanical forces, intentional self-harm and interpersonal violence; alcohol-use disorders; fetal alcohol syndrome.

Source: Lim et al., 2012 (1). *Note*: * low regular doses of alcohol associated with reduced risk.

For health harms, an Australian study estimated that the lifetime risk of dying from an alcohol-related condition increased as alcohol consumption increased, and at the same rate for men and women (11). At a consumption level of 20g alcohol (two drinks) per day, the lifetime risk of dying from an alcohol-related condition was 1 in 100; the risk increased to 14 in 100 at a consumption level of 80g (1 bottle of wine) per day. Much store is put on alcohol's cardiovascular protective effect but it needs to be remembered that alcohol use is overwhelmingly detrimental to many cardiovascular outcomes (12). For ischaemic heart disease, the protective effect disappears when drinkers report at least just one heavy drinking occasion (five drinks) per month (13) and is attenuated in overweight drinkers (14). A greater reduction in risk of death can be obtained by being physically active and eating a healthier diet (15). Considering alcohol-related deaths, including ischaemic heart disease, an English study estimated that for men and women under 75 years, the level of consumption with the lowest risk of death was 3g a day, some 10 times lower than the recommended consumption limits (16).

At a societal level, the prevalence of alcohol-related harm increases with the average volume of daily alcohol consumption (17). In 2005, the latest year of available data, global alcohol consumption was estimated to be 6.1 litres of alcohol per adult per year (18). This is more than 13g of alcohol (over 1 can of beer) per day. Given that about one half of the world's adult population does not drink, this means a global average of 26g alcohol per day per drinker: 2.5 cans of beer. Unrecorded consumption (informal production, illegal production, tax evasion and illegal trading) accounts for nearly 30% of this global consumption, just under 50% in low-income countries and just over 10% in high-income countries.

Deaths due to alcohol

In 2010, the latest year of summarized data, it has been estimated that alcohol was the cause of some 2.7 million deaths, increasing from 2 million in 1990 (1). Over two fifths of alcohol-caused deaths result from intentional and unintentional injuries; over one fifth from cancers; and one seventh from cardiovascular diseases and diabetes mellitus. Nearly one half of all liver cirrhosis deaths and one third of all deaths from epilepsy, violence, cancer of the oesophagus and cancer of the liver are due to alcohol consumption. The contribution of heavy drinking (40+g of pure alcohol per day for women, 60+g for men) and alcohol dependence to alcohol-related mortality has been studied in the EU. About 80% of all alcohol-related deaths (net of any protective effect) occur in people who are heavy drinkers or alcohol dependent and about 70% of all alcohol-related deaths occur in people who are alcohol dependent (19).

Disability and deaths due to alcohol

It has been estimated that alcohol was the cause of 121 million DALYs lost worldwide in 2010, increasing from 89 million in 1990 (1). Hence, alcohol has moved from eighth to fifth most important risk factor for DALYs after high blood pressure, tobacco use (including second-hand smoking), household air pollution from solid fuels, and diets low in fruits.

Underestimate of alcohol's true burden

The numbers of alcohol-caused deaths and lost DALYs remain an underestimate since, for the 2010 estimate, they do not include all alcohol-use disorders (alcohol dependence is included, but not harmful alcohol use) or all alcohol-related infectious diseases, such as HIV/AIDS. For example, including alcohol-related infectious diseases as well as HIV/AIDS increased the proportion of all alcohol-related DALYs lost in South Africa from 7.8% to 14.6% for men and from 1.4% to 3.9% for women (20).

Economic costs due to alcohol

A range of studies across the world find that economic costs from alcohol's impact on health, well-being and productivity reach some US$PPP 300–400 per head of population in any one year. Well over one half to two thirds of all of these costs are due to lost productivity (2).

Economic crises and alcohol

Per capita consumption of alcohol tends to decrease at times of economic crisis and increased unemployment. However, both episodic heavy drinking and deaths from alcohol-related disorders increase. An analysis of associations between changes in employment and mortality for 26 European countries between 1970 and 2007 found that a more than 3% increase in unemployment was accompanied by a nearly 5% increase in suicides in those under 65 years and 28% more deaths from alcohol-use disorders (21). The Russian case study (Case study 11.1) shows the dramatic impact that socioeconomic crises can have on alcohol-related mortality. See also Chapter 5 for a related discussion.

Inequalities and alcohol

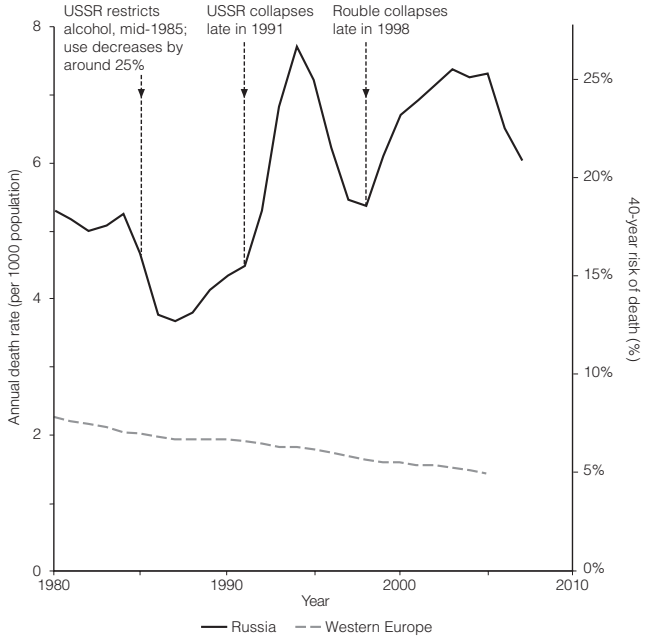
For the same amount of alcohol consumed, people living in lower-income regions of the world have higher numbers of alcohol-related deaths and DALYs lost than those in higher-income regions (20). The same applies within countries: for the same amount of alcohol consumed, there are more alcohol-related deaths among people with lower incomes than those with higher incomes (22).

Case study 11.1 *Alcohol-related mortality in Russia*

Russia provides an interesting, if not dramatic, case study of how economic crises impact on deaths from alcohol-related diseases. All-cause mortality rates at ages 15–54 years in Russia and western Europe since 1980 are compared in the figure. After increasing slowly for many years, alcohol consumption decreased suddenly in mid 1985 as part of the Gorbachev alcohol campaign, was minimal during 1986–87 at about three-quarters of pre-1985 levels, increased (slowly, then steeply), and was at a maximum in 1994. During 1992/1994, Russian industrial output halved, accompanied by hyperinflation; the rouble then stabilized (1995–98), collapsed (1998–99), and stabilized again. Extraordinarily, alcohol was responsible for about three quarters of all male Russian deaths at ages 15–54 years and about half of all female Russian deaths at these ages during the 1990s.

Decreases in total alcohol consumption and mortality have been noted since 2005, when the Russian government initially adopted the regulation of alcohol production and sale. The consumption changes were driven by decreases in recorded and unrecorded spirit consumption, only partly compensated by increases in beer and wine consumption.

Mortality from all causes and 40-year risks of death in men and women aged 15–54 years in Russia (1980–2007) and western Europe (to 2005)

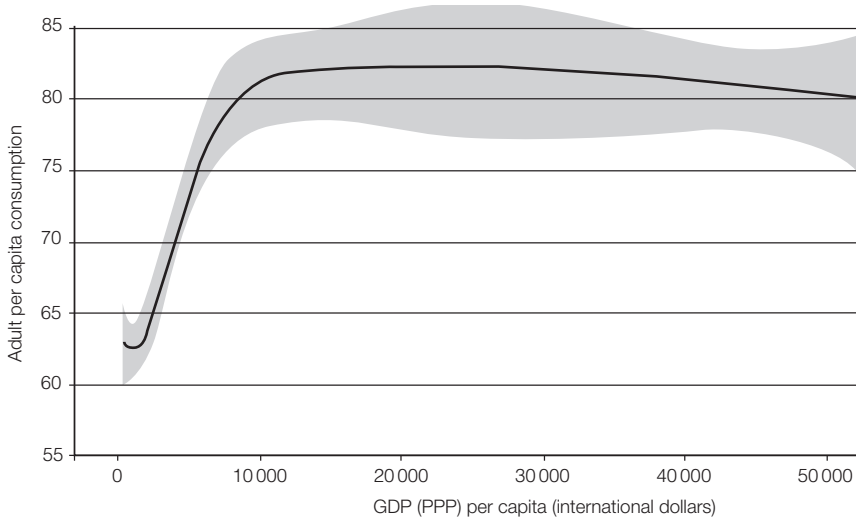


Source: Zaridze et al., 2009 (23); Neufeld & Rehm, 2013 (24). *Note*: USSR=Union of Soviet Socialist Republics.

Economic development and alcohol

Per capita adult alcohol consumption increases in line with increases in GDP, at least up to a GDP of US$PPP 10 000, largely driven by abstainers starting to drink (Fig. 11.1) (25). Hence, it is crucial to have effective alcohol policies in place to manage expected increases in consumption and harm arising from economic development.

Fig. 11.1 *Relationship between recorded adult per capita alcohol consumption and GDP for 189 countries across the world*



Source: Shield et al., 2011 (25).

11.3 Effective policies for reducing the harm of alcohol

1. Best buys for alcohol policy are price increases, limits on availability and bans on advertising.
2. Jurisdictions with high levels of unrecorded consumption should focus efforts on bringing informal and illicit markets under effective government control.
3. Introducing a minimum price per gram of alcohol sold is likely to be an effective policy option.
4. Restricting the hours of sale of alcohol can save lives.
5. Self-regulation of commercial communications does not work – the only effective option is a ban on all forms of marketing, including marketing through social media.
6. The health sector is crucial for providing brief interventions for heavier drinkers, treatments for alcohol dependence and for promoting joined-up action to reduce the harm done by alcohol across different disease groups, including infectious diseases.
7. Rather than individual policy options, comprehensive policies should be implemented to maximize health gain.

Alcohol's global harm is preventable and there is a very extensive evidence base to inform the implementation of effective alcohol policy (26–28). The WHO summarizes this evidence by estimating the impact of policies, their costs and cost effectiveness as shown in Table 11.1 for three culturally and geographically distinct WHO subregions: (i) countries of the Americas Region with low child and adult mortality (AmrB), including Latin American countries such as Brazil and Mexico; (ii) countries of the European Region with low child mortality but high adult mortality (EurC), including countries such as the Russian Federation and Ukraine; and (iii) countries of the Western Pacific Region with low child and adult mortality (WprB), including countries such as China and Viet Nam. Table 11.1 shows that the three best buys for alcohol policy are price increases, limits on availability and bans on advertising.

Specific intervention strategies need not be (and are not) implemented in isolation but should be combined to maximize possible health gains up to the point where it remains affordable to do so. The optimal mix of interventions at different spending limits will depend on the relative cost and cost effectiveness of the individual components, as well as the synergies that exist between them. Table 11.1 includes an example of a wide-ranging combination strategy showing that while cost effectiveness is maintained, implementation costs naturally go up.

11.3.1 Price increases

Tax increases represent the most cost-effective response in countries with a high prevalence of heavy drinking (each DALY saved costs less than I$ 500 in both the American and eastern European subregions). In lower-prevalence contexts (including the Western Pacific subregion in which women use alcohol relatively infrequently) population-level effects drop off and cost-effectiveness ratios rise accordingly. The effect of alcohol tax increases is mitigated by illegal production, tax evasion and illegal trading. Reducing this unrecorded consumption via concerted tax enforcement strategies by law enforcement and excise officers is estimated to cost more than a tax increase but – at least in the three subregions included in the table – produces similar levels of effect. In settings with higher levels of unrecorded production and consumption (e.g. India) it may be a more effective pricing policy to increase the proportion of consumption that is taxed (therefore more costly to the price-sensitive consumer) rather than simply increase excise tax (may only encourage further illegal production, smuggling and cross-border purchases).

A number of points require consideration when managing alcohol taxes.

1. The affordability of alcohol in comparison to income and other goods is key (29). Alcohol consumption tends to increase if the price of alcohol stays the

Table 11.1 *Cost and cost effectiveness of interventions relating to different target areas for alcohol public health policy*

Target area Specific intervention(s)	**Coverage**	**WHO subregion *(exemplar countries)***					
		Americas: AmrB *(e.g. Brazil, Mexico)*		**Europe: EurC *(e.g. Russia Federation, Ukraine)***		**Western Pacific: WprB *(e.g. China, Viet Nam)***	
		Annual cost per capita (I$)[1]	**Cost per DALY saved (I$)[2]**	**Annual cost per capita (I$)[1]**	**Cost per DALY saved (I$)[2]**	**Annual cost per capita (I$)[1]**	**Cost per DALY saved (I$)[2]**
1 Raising awareness & political commitment							
School-based education	80%	0.29	N/A	0.34	N/A	0.53	N/A
2 Health sector response							
Brief interventions for heavy drinkers	30%	1.04	3870	1.78	2671	0.42	2016
3 Community action							
Mass media campaign	80%	0.31	N/A*	0.79	N/A	0.19	N/A
4 Drink-driving policies & countermeasures							
Drink-driving legislation & enforcement (via random breath-testing campaigns)	80%	0.44	924	0.72	781	0.24	1262
5 Addressing the availability of alcohol							
Reduced access to retail outlets	80%	0.24	515	0.47	567	0.16	1307
6 Addressing marketing of alcohol beverages							
Comprehensive advertising ban	95%	0.24	931	0.47	961	0.16	955
7 Pricing policies							
Increased excise taxation (by 20%)	95%	0.34	277	0.67	380	0.20	1358
Increased excise taxation (by 50%)	95%	0.34	241	0.67	335	0.20	1150
Tax enforcement (20% less unrecorded)	95%	0.56	468	0.87	498	0.37	2603
Tax enforcement (50% less unrecorded)	95%	0.63	476	0.93	480	0.43	2733
Combination strategy[3]		2.35	691	4.10	754	1.31	1704

Source: Anderson, Chisholm & Fuhr, 2009 (26).
Note: For a full list of Member States by WHO subregion see http://www.who.int/choice/demography/regions.
[1] Implementation cost in 2005 International dollars. [2] Cost-effectiveness ratio, expressed in I$ per DALY saved in 2005.
[3] Brief advice, random breath-testing, reduced access, advertising ban, plus increased tax (by 50%) and its enforcement (50% less unrecorded consumption). N/A: not applicable because effect size not significantly different from zero (cost-effectiveness ratio would therefore approach infinity).

same and incomes go up, or the relative price of other goods in the shopping basket goes up.

2. Specific or targeted alcohol taxes do not always work. The German alcopop tax resulted in consumption switching from spirit-based mixed beverages to beer-based mixed beverages (30). In Australia, despite substitution, there was some evidence for an overall drop in consumption (31).
3. Where there is large informal or illicit production of alcohol, effective implementation of tax increases requires efforts to bring such production under effective government control. Closure of illegal factories and after-hours production and the gradual inclusion of informal alcohol production within a government licensed system are examples of effective measures (26).
4. Cross-border purchasing driven by differing alcohol prices in neighbouring jurisdictions is less important than imagined and some well-meaning responses can worsen matters. In 2004, Finland dropped alcohol taxes by one third in order to reduce the incentive for consumers to buy cheaper alcohol from Estonia when it joined the EU. One unintended consequence was a sudden and immediate jump in alcohol-caused deaths, the vast majority of the 17% increase occurring amongst poorer rather than richer consumers. Alcohol-related deaths decreased when Finland raised taxes in 2008 (32).
5. Alcohol is best taxed per gram, as a rational reflection that it is the number of grams of alcohol that matter for health (in some countries, alcohol is not subject to excise tax).
6. Producers and retailers respond differently at different times: sometimes the price rise is higher than expected but a tax increase is not always followed by an equivalent price increase (33). More commonly, the price goes up less than expected as producers and retailers use their capacity to absorb some of the tax increase.
7. Setting a minimum price per gram of alcohol sold prevents retailers from undercutting price and tax increases and targets heavy drinking occasions more effectively than general tax increases, with immediate effect in improving health and well-being (34). This has been applied for years in some Canadian provinces, with good effect (35). In Europe, both Scotland and England are discussing the introduction of a minimum price per gram of alcohol.

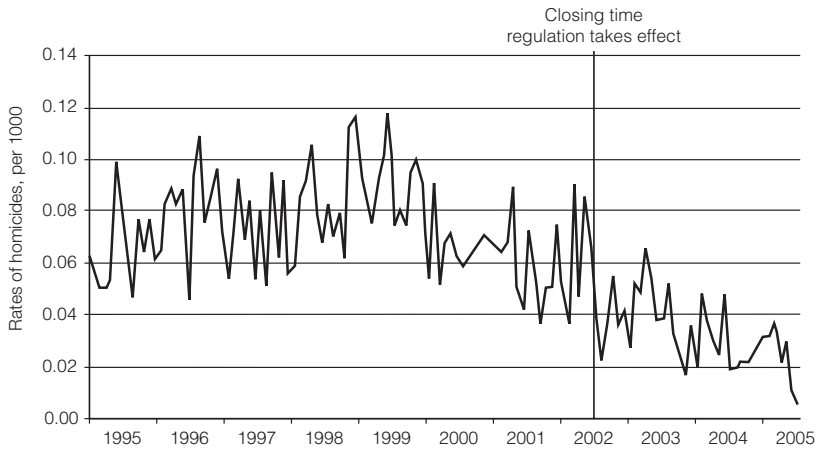
11.3.2 Limits on availability

Wherever and whenever studied, the impact of availability on alcohol consumption and alcohol-related harm shows consistent conclusions (36). When alcohol is easier to obtain, more alcohol is consumed and more harm results; when alcohol is more difficult to get, less is consumed and less harm results. So, lives are saved by reducing the number of outlets and the days and hours of sale. The case study on Diadema in Brazil (Case study 11.2) illustrates the impact on homicide rates following introduction of a 23.00 closing time for on-premise sales.

Case study 11.2. *Reducing murder rates in Diadema, Brazil*

Homicide is one of the leading causes of death in Brazil. Local policy measures were introduced in response to the city of Diadema having one of the highest murder rates. These included a new licensing law in 2002 prohibiting on-premise alcohol sales after 23.00. Homicide and assault data from local police archives were analysed to evaluate the effect of restricting alcohol availability through limiting opening hours. Models were adjusted for contextual conditions, municipal efforts and law enforcement interventions that took place before and after adoption of the closing-time law. Taken from the study by Duailibi et al. (2007), the graph displays the monthly rates of homicide per 1000 residents from 1995 to 2005.[1] Homicide rates in Diadema dropped significantly following the introduction of limited opening hours – to a 44% decline in murders.

Monthly rates of homicide per 1000 residents, Diadema, 1995–2005



Source: Duailibi et al., 2007 (37).

Many countries use a form of alcohol sales regulation in which the government monopolizes ownership of one or more types of retail outlet. In addition to limiting outlet density and the hours and days of sale, such monopolies remove the private profit motive for increasing sales. There is substantial evidence that such monopolies reduce alcohol consumption and alcohol-related harm (36). In many parts of the world, widespread community concern relating to alcohol has led (particularly in more remote communities) to implementation of restrictions on availability as part of extensive programmes. There is some evidence of success when such restrictions are implemented with full community support (27).

11.3.3 Bans on advertising

The producers of alcoholic beverages market their products so as to encourage consumption. This is a multifaceted, strategic and long-term endeavour which starts with product development and innovation and uses commercial communications to extol the benefits of, and remove barriers to, consumption (Fig. 11.2).

Fig. 11.2 *Multifaceted character of marketing*

Source: Davis et al., 2008 (38).

The evidence shows that commercial communications, particularly through social media and electronic communication outlets, encourage non-drinking teenagers to start drinking and existing teenage drinkers to drink more (39, 40). Even just watching a one-hour movie with a greater number of drinking scenes, or viewing simple advertisements, can double the amount drunk over the hour's viewing period (41). Many jurisdictions put much store on self-regulation of commercial communications and withdrawal of those that are found to breach self-regulatory codes. However, these approaches not only do not work (42, 43) but also are irrelevant. Extensive evidence shows that withdrawn commercial communications remain accessible to all in social media (30) which are, in any case, heavily financed by global alcohol producers. The experience of alcohol policy in Zambia (Case study 11.3) describes how alcohol marketing influences drinking among Zambian children, and how the Zambian Government is responding with a national alcohol policy.

11.3.4 The health sector

As documented in Table 11.1, there is considerable evidence for the effectiveness and cost effectiveness of brief interventions for heavier drinkers in a range of primary-care and general hospital settings (44). In addition, treatment for individuals with alcohol dependence can bring considerable health gain (19). The health sector is also crucial for promoting joined-up action to reduce the harm done by alcohol across different disease groups (20). This is even more important in lower-income countries where alcohol-related infectious diseases play a prominent role. Alcohol increases the risk of a range of infectious diseases (including community acquired pneumonia, TB and HIV/AIDS) and impairs treatment compliance for both TB and HIV/AIDS (20). This supports calls for comprehensive actions such as the implementation of brief interventions and other alcohol treatment options integrated within the treatment system for infectious diseases, included within integrated alcohol policy packages to minimize harm (45).

11.4 Assessment of response to date: the politics of alcohol consumption

1. Given that the goal of alcohol policy is to reduce the harm done by alcohol, the fact that alcohol moved from the eighth to the fifth most important risk factor in the world for DALYs between 1990 and 2010 indicates that alcohol policy is failing.
2. China and India are home to over one third of the world's population, so their continuing economic growth will produce inevitable global increases in alcohol consumption and alcohol-related harm.
3. Global responses to alcohol are weak: WHO's Global Strategy to Reduce the Harmful Use of Alcohol contains no legally binding elements, and the 2011 United Nations High-level Meeting on the Prevention and Control of Non-communicable Diseases made scant reference to alcohol.
4. Too often, trade and industry interests trump public health interests for alcohol.

The goal of alcohol policy is to reduce the harm caused by alcohol. As already noted, the relative importance of alcohol as a cause of death and disability increased from eighth place in 1990 to fifth place in 2010. There is no doubt that the global figures hide many individual country variations, and there are certainly individual country success stories but, at a global level, the evidence would suggest that alcohol policy is failing. Three of the many reasons for this are considered below. These both influence, and are influenced by, country policy – after all, a global response is determined by individual countries and is the aggregate of individual country responses.

First, economic development and urbanization increase alcohol consumption and thus alcohol-related harm. Continuing economic growth in India and China, home to over one third of the world's population, will inevitably drive global increases in alcohol consumption and alcohol-related harm. Global alcohol producers are very active in using intensive marketing actions to capitalize on the opportunities of untapped markets.

Second, global responses to alcohol to date are rather weak. The 2010 WHO Global Strategy to Reduce the Harmful Use of Alcohol is a voluntary agreement, contains no legally binding elements and is supported with only minimal resources (46). The 2011 Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases made scant reference to alcohol and simply called for implementation of the WHO Global Strategy (47). Global alcohol producers have been highly active in attempting to derail governmental global responses (48).

Third, too often trade interests are allowed to trump health interests for alcohol. For example, per capita alcohol consumption in the EU is more than twice the

world average and alcohol is a cause of 1 in 8 of all deaths amongst those aged 15 to 64 (49). It has been argued that the European Commission's response to the problem – the Communication on alcohol – failed to reflect evidence for effective policy and appeared to prioritize trade and industry interests (50). At the European level, alcohol producers have been closely involved in policy development and implementation. Across the EU Member States it has been found that the greater the alcohol producers' involvement in alcohol policy development, the weaker the alcohol policy (51).

11.5 What could make a difference

1. Adequate infrastructure is needed for effective alcohol policy – legislation can be successful only when underlying governmental structures support its implementation.
2. The alcohol industry's involvement in policy-making is a major barrier to a public health oriented action plan on alcohol, should be treated with intense suspicion and avoided wherever possible.
3. The alcohol industry should withdraw from the market products with demonstrable liability (e.g. high-strength beers and liquor sachets) and should cease activities designed to reduce or eliminate evidence-based activities.
4. Civil society needs to be better mobilized to support normative societal change for non-drinking and lower-risk drinking.
5. Academia can be more proactive in initiating dialogues with policy-makers to ensure greater emphasis on implementing evidenced-based alcohol policies.
6. An international treaty modelled on the FCTC should be adopted to institutionalize public health interest in alcohol as a special commodity, and to provide a frame for joint international action to reduce the harm caused by alcohol globally.

11.5.1 Infrastructure for alcohol policy

Effective action to reduce alcohol-related harm is dependent on the requisite infrastructures for policy development, priority-setting, monitoring and surveillance, research and evaluation, workforce development and programme delivery being in place (52). Despite some advances in building core infrastructures for action on alcohol, it can be argued that there is continuing insufficient political will and investment by both private and public sectors in many countries. Hence, it remains a challenge to ensure that this infrastructure is sufficiently large and capable.

Responsibility for developing and implementing a national action plan on alcohol is usually split between several governmental departments and levels.

The departments involved can include those devoted to industry and trade, agriculture, employment, finance, transport and health. These different sectors often have conflicting interests and priorities for alcohol policy and may also wield power unequally. From a public health perspective, common barriers to effective action on alcohol include the economic and political priorities of free trade; unfettered marketing; unrestricted access to alcohol; governmental perceptions about the economic importance of the alcohol industry; and the potential unpopularity of certain actions. A lack of political support for public health issues and a deference to financial concerns are commonly identified as obstacles to effective action on alcohol. Gaps between alcohol-related evidence and action in a particular country, as well as its particular choice of action, will be determined by the government's mix of actors and how it resolves policy conflicts. Ultimately, legislation can be successful only when the underlying governmental structures support its implementation.

National politicians have the authority to regulate and influence the environment in which alcohol is sold and marketed. They often have particular interests in alcohol issues, varying according to their official roles as well as their personal views, financial interests and social networks. Contacts with players outside government (e.g. alcohol industry, health groups) can shape politicians' views on specific alcohol policies and influence the forming or refining of policy proposals. Since politicians are influential players in the policy arena, their political support for the content of alcohol action plans is crucial. The Zambian case study illustrates how a sudden increase in alcohol-related deaths opened opportunities for a national alcohol plan (Case study 11.3).

Case study 11.3 *Developing alcohol policy in Zambia*

In Zambia, it is estimated that 70% of all alcohol consumed is unrecorded, with more than two fifths of 11–16 year olds consuming alcohol. A 2004 study of students in this age group found that alcohol marketing, specifically provision of free alcohol through a distribution representative, was associated with drunkenness (AOR = 1.49; 95% CI: 1.09–2.02) and problem drinking (AOR = 1.41; 95% CI: 1.06–1.87) after controlling for demographic characteristics, risky behaviours and alcohol education. Alcohol education was shown not to reduce drunkenness or problem drinking.

In April 2012, the Zambian Government banned the manufacture and sale of Tujilijili liquor sachets. This 45% alcohol spirit sold in 50 ml sachets at a cost of 10 US cents, had a far-reaching distribution network across the country and was commonly sold to minors. Local politicians, teachers and headteachers, youth leaders and religious leaders had frequently expressed

Case study 11.3 *contd*

their concern about young people and children drinking these sachets. Further public concern was caused by the fact that several people died from consuming Tujilijili in large quantities.

The Ministry of Health has also drafted a national alcohol policy which identifies alcohol as a public health problem and provides a policy framework which includes regulation of the alcohol market; protection of young people; prevention and education; treatment and care for those affected by alcohol problems; communication; multisectoral action; and research and development.

Source: Swahn et al., 2011; Jernigan, 2012 (53, 54).

Lack of transparency and information; conflicts of interest; poor organization and poor preparation for the introduction of new policies and laws; government organized vertically rather than horizontally; a lack of financing; corruption; and public distrust of authority are all impediments to the acceptance, implementation and enforcement of effective policy. The British Government provides a number of lessons for effective policy within the Government's Alcohol Strategy (Case study 11.4).

Case study 11.4 *Lessons from the British Government's strategy on alcohol*

In March 2012, the British Government launched a new strategy on alcohol focused on reducing the health and social impacts of binge drinking – the Government's Alcohol Strategy. In the words of the Prime Minister: "Binge drinking isn't some fringe issue, it accounts for half of all alcohol consumed in this country. The crime and violence it causes drains resources in our hospitals, generates mayhem on our streets and spreads fear in our communities" (55).

The strategy is innovative as it focuses on alcohol as the cause of problems, rather than the 'harmful use' of alcohol; promotes joined-up action across different government sectors and is evidence based and aligned with alcohol policy best buys. The proposal to introduce a new minimum price per gram of alcohol will make it illegal for shops and pubs to sell alcohol for less than this set price. The government estimates that a 40 pence cost per 8g unit would translate into 50 000 fewer crimes and 9000 fewer alcohol-related deaths per year.

The strategy recognizes that the alcohol industry has a direct and powerful connection and influence on consumer behaviours. It is noted that people consume more when prices are lower; marketing and advertising affect

Case study 11.4 *contd*

drinking behaviour; and store layout and product location affect the type and volume of sales. It also anticipates the removal of 10 million litres of pure alcohol from the British market by 2015 as the alcohol industry introduces lower-strength products and smaller servings. This will have no impact on profits as this alcohol will simply not be produced or consumed. This will be incentivized through a higher rate of duty for higher-strength beer and a lower rate of duty for lower-strength beer in order to align beer duty more closely to alcohol strength.

Source: Anderson, 2012 (56).

11.5.2 The alcohol industry

The alcoholic beverage industry is a pressure group that enters the policy arena to protect its commercial interests (57). Pressure groups have a varying ability to influence alcohol policy action, and some are more powerful than others. The alcohol industry generally wields a great deal of economic, political and organizational power in the global policy arena, but now particularly in emerging economics and in many low-income African countries (54). The various parts of the industry often form lobbies and coalitions to foster their common interests and, increasingly, these interests agree on policy options (48). Key phrases in the WHO Global Strategy regarding industry consultation have been used as justification to promote industry-favourable policies without the participation of WHO or the public health community (46).

A cornerstone of industry action is to develop, promote and disseminate educational materials and programmes designed to prevent and reduce underage purchase and consumption (48). However, this is both inappropriate and misguided since systematic reviews have consistently failed to identify educational materials that are capable of reducing underage drinking and alcohol purchases (58).

Another cornerstone of the alcohol industry's strategy is the introduction and frequent revision of voluntary marketing codes of practice, including their expansion to include digital media (48). This action is also misguided since research on industry self-regulation codes finds that exposure targets and content guidelines of such voluntary codes are systematically violated and the codes are inadequate for protecting vulnerable populations from the negative effects of alcohol marketing (42, 43).

Funded by global alcohol producers, the International Center for Alcohol Policies (ICAP) has been involved in the development of national policies for

governments in Africa and Asia. In one case, at ICAP-sponsored meetings, national plans were formulated to fit the specific needs of four different African countries. These plans were found to originate from a senior executive of SABMiller, one of ICAP's funders (59).

Through ICAP, global alcohol producers are now moving into direct funding of contract research that will be published in peer-reviewed journals. As shown by one analysis of the moral hazards of alcohol industry funding, this kind of direct industry funding carries the risk of bias, agenda setting and even reputational damage to the research field (60). With the anticipated publication of a series of case studies, it is likely that research on non-commercial alcohol (accounting for more than one third of world production) will be dominated by a literature tainted by a major conflict of interest. A specific example of potential problems is illustrated by the Tavern Intervention Programme for Men (TIP), funded by the Global Fund and implemented by SABMiller and its partners in South Africa. TIP is designed to minimize alcohol-related harm in men and reduce the spread of HIV/AIDS. A review of this programme concluded that the alcohol industry supports alcohol interventions that have limited impact on drinking at a population level. These interventions allow the industry to be seen to be fulfilling social and legal obligations to address the harm done by alcohol while simultaneously ensuring that sales and profits are maintained (61).

Thus, the stark discrepancy between research findings on effective alcohol policy options on the one hand, and the actual form of alcohol policies on the other, can often be attributed to the central and dominant role of commercial interests in the policy-making process. The alcohol industry's involvement in policy-making should be treated with intense suspicion and avoided wherever possible.

11.5.3 Forcing action by producers and retailers

Global alcohol producers have a responsibility for their behaviour all over the world, and should adhere to minimal standards for product design and marketing practices regardless of the country in which their products are sold. They should stop the development of products that facilitate alcohol intoxication and withdraw from the market products with demonstrable liability, such as high alcohol content beers and liquor sachets. They should reduce the alcohol content of existing products in order to minimize the toxic effects of regular drinking and the likelihood of acute intoxication. They should cease engagement in health-related prevention, treatment, research and traffic safety activities, as these tend to be ineffective and self-serving. They should cease their advocacy, lobbying and political activities designed to reduce or eliminate evidence-based alcohol policies.

11.5.4 Strengthening the voice of civil society

One source of response to the power of the alcohol industry could be opposition pressure groups, including health-based NGOs (62). In comparison to the industry, however, such NGOs usually have less access to policy-makers and fewer political and financial resources. In many countries, the lack of an organized and resourced civil society and failure to mobilize public opinion have been identified as obstacles to alcohol policy reform. Across EU Member States, evidence has found that health-related NGOs' level of involvement in alcohol policy-making bore no relationship to the strength of alcohol policy (51). Institutions that could support public health-oriented alcohol policy include independent, publicly funded institutions; insurance industry programmes; issue-based organizations and networks; and professional associations. Relative autonomous health promotion foundations funded by dedicated taxes on alcohol (and tobacco) are a useful approach.

Civil society can play an important role in changing norms around alcohol consumption (63). Implementation of effective policy actually changes norms, since support for policy measures tend to increase after their implementation (27). Social networks are strong influencers of behaviour. Changes in alcohol consumption within a person's social network have a significant effect on that person's subsequent behaviour, in terms of not drinking (when more of the network abstain) or drinking heavily (when more of the network drink heavily) (64).

11.5.5 Science and research

Other important infrastructural elements supporting a robust alcohol policy include science and research systems, which help expand the knowledge base for effective action on alcohol (52). Research can identify problems, evaluate and analyse programmes and policies, and recommend strategies. Unfortunately, there is often a stark discrepancy between scientific evidence on the effectiveness of alcohol policy measures and the actual policy options that governments consider (65). Research appears to be most influential in setting a policy agenda and considering policy alternatives; less influential when amending draft laws; and least influential in decision-making. Scientists can also take a role in initiating dialogues with policy-makers over important policy topics (66). Across EU Member States, evidence has found that the greater the involvement of academia in alcohol policy-making, the stronger the alcohol policy (51).

11.5.6 Umbrella of a global legally binding agreement

The geographical breadth of the evidence base is changing rapidly. Still, most of the evidence for effective alcohol policy comes from either Anglophone or Scandinavian countries in which alcohol use is commonly characterized by low rates of abstinence and relatively high rates of heavy episodic drinking. Many of these societies have a tradition of government regulation of the sale of alcohol. For them, increased adoption of evidence-based alcohol policies is often a matter of recovering a lost policy tradition that has been abandoned in the face of the deregulatory phase of the past three or so decades. Many low-income countries are in a very different situation, often having: little or no tradition of government regulation of alcohol; an alcohol industry that is expanding its markets; and few civil society organizations attempting to reduce alcohol-related harm.

Alcohol is the only major dependence-producing psychoactive substance causing substantial health problems which is widely used worldwide and at present not covered by any international treaty. Many argue for the adoption of a new international treaty on the model of the FCTC to institutionalize the public health interest in alcohol as a special commodity, and to provide a frame for joint international action to reduce the harm done by alcohol globally (3) (see also Chapter 10 on tobacco).

11.6 Conclusions

1. Recognizing that the health of their citizens is of paramount concern, governments should be active in reducing the harm done by alcohol.
2. Governments must implement the best buys for alcohol policy, recognizing that healthy solutions for alcohol are not necessarily costly solutions.
3. Governments must effectively regulate the alcohol industry.
4. NGOs need to step up their activities as watchdogs and voices for effective alcohol policy.
5. An international health policy in the form of a framework convention for alcohol control is urgently needed.

Recognizing that the health of their citizens is of paramount concern, governments should be active in reducing the harm done by alcohol

Given that alcohol is the world's fifth most important risk factor for disability and premature death, no government can fail to implement effective action to reduce the harm done by alcohol. Government action alone is not sufficient

but is nevertheless absolutely essential: there are powers only governments can exercise, policies only governments can mandate and enforce, and results only governments can achieve. To halt the worldwide epidemic of alcohol-related diseases, governments at all levels must make healthy solutions the default social option.

Governments must implement the best buys for alcohol policy, recognizing that healthy solutions are not necessarily costly solutions

Governments need to recognize that changing the social and physical environment is far more effective than changing individual behaviour alone. This means bringing informal and illicit alcohol markets under government control, raising alcohol taxes and introducing a minimum price per gram of alcohol sold; reducing availability by reducing outlet densities and days and hours of sale; and, as for tobacco, banning all forms of commercial communications. Such social and physical changes that make the healthiest route are also the easiest to follow. The WHO analysis (Table 11.1) illustrates that the three best buys are not costly solutions to implement in all regions of the world. And raising alcohol taxes raises public revenues.

Governments must effectively regulate the alcohol industry

The alcohol industry is effectively the vector for alcohol-related harm as alcohol-related harm results from alcohol – the industry's product. This is an industry that largely acts with impunity and, as has been repeatedly demonstrated, is unable to regulate itself properly. In 2005, an article in *The Economist* asserted that the business of business is business; it should meet the needs of its shareholders and not meddle in policies that impact on human well-being (67). The latter is the role of governments who are answerable to the people and who, when it comes to reducing externalities and regrettables, need to regulate the environments in which businesses operate. *The Economist* article continued by warning of the need to be highly suspicious when the two (governments and industry) work together on policy.

NGOs need to step up their activities as watchdogs and voices for effective alcohol policy

A major scaling-up of activity both nationally and internationally will need increased resources to enable advocacy from well-informed voices that are independent of commercial interests. The tobacco experience shows that investment in the NGO sector can catalyse and support national action. However, NGO engagement in the alcohol policy arena is severely constrained by a lack of resources (3). In 2008, Bloomberg Philanthropies and the Bill & Melinda Gates Foundation made a US$ 500 million contribution to address the

tobacco epidemic but this has not been matched for alcohol — an equally urgent and challenging issue. Nor has alcohol advocacy had the benefit of funding from charitable foundations, such as cancer societies and heart foundations, which have been supportive of anti-tobacco activity. A useful national model is a hypothecated tax or levy on alcohol sales which is then used to fund NGO activity. For example, the StopDrink Network in Thailand provides a model of active linkage with all elements of civil society and has taken a proactive role in supporting alcohol policy. It has been supported by ThaiHealth, which is funded by an earmarked 2% tax on alcohol and tobacco.

An international health policy in the form of a framework convention for alcohol control is urgently needed

In view of the comparability of tobacco and alcohol, plus the precedent established by the FCTC, calls for a framework convention on alcohol control are not surprising. The WHO Expert Committee on Problems Related to Alcohol Consumption urged WHO to analyse the feasibility of international mechanisms, including legally binding agreements (62). The CSDH stated that alcohol is a prime candidate for stronger global, regional and national regulatory controls (68). Many of the key elements needed or encouraged by the FCTC are comparable to the most effective measures for alcohol and the framework convention approach is the least prescriptive of the legally binding international instruments available. However, its strength lies in the use of international law to establish an institutionalized forum for cooperation and negotiation.

Upon ratification, countries undertake to apply the principles of the convention in national law and also engage in multilateral information exchange. Effects of international agreements are as much about domestic policy as about control across borders. The FCTC process triggered development of national tobacco control by expanding the numbers of stakeholders participating in tobacco control (69) (see Chapter 10). A framework enhances rapid implementation of national policies in LMICs because development aid, including technical advice, is more likely to be provided. In view of the general decrease in implementation of effective alcohol-control policies in recent decades, and the threats posed by globalization, there is an urgent need for such assistance and impetus at the national level.

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Chapter 12

Lessons from environment and health for HiAP

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Key messages

- The history of environment and health has a wealth of HiAP examples, from rapid focused actions to long-term cooperation between sectors.
- Environment governance mechanisms, including regulations and international treaties, are well-developed and have important implications for many environmental health issues.
- Environment and health encompasses, but goes well beyond, the health implications of environmental policies: by and large, it is about the health and environment implications of other sectors' policies.

12.1 Introduction

This chapter provides an overview of how environment and health have been integrated into policies in many sectors, drawing lessons for intersectoral decision-making and for achieving HiAP.

The chapter is divided into four sections. The first provides an overview of environmental health's contributions to policy-making, drawing on a non-linear policy-making framework with three streams (problems, policies and politics). The second provides examples of HiAP approaches implemented in environmental health policies. The third summarizes lessons learned from the experience of mainstreaming environment and health considerations into

1 The views expressed in this chapter do not necessarily reflect the views of the World Health Organization

different decision-making processes, using instruments such as environmental and health impact assessment. The final section of the chapter outlines a way forward for HiAP that seeks to harness 'health governance' opportunities provided by renewed interest in sustainable development.

12.2 Overview – environment and environmental health problems, policies and politics

12.2.1 Physical and built environment

Environmental determinants of health are directly influenced by social and economic interests that lead to overexploitation of natural resources and pollution. They also threaten the planet's capacity to cope with severe alterations to the ecological systems on which the very existence of human life depends. Health is particularly associated with changes in the natural environment that are man-made; many potential synergies for health and environment protection arise from focusing on the root causes of health and environmental degradation.

One fourth of the global burden of disease can be prevented through known strategies to manage environmental health risks such as air and water pollution, food contamination, injuries and safe opportunities for physical activity in daily life (1). Behaviours are often conditioned by culture and peer pressure and linked to circumstances within which people live, work or play. They may change only if environmental constraints are addressed, lowering the barriers that prevent the adoption of different lifestyles and consumption patterns in order to "make the healthier choice the easier choice" (2).

The causes of environmental degradation in different sectors of the economy are often determinants of health. Decisions that guide urban planning, transport and housing development can create rather than reduce air pollution, noise and traffic injuries. These same policies can limit rather than promote daily physical activity and lead to NCDs. Another example is the lack of access to clean energy where poor households rely on solid fuels such as biomass fuels (agricultural residues, dung, straw, wood) or coal for their basic cooking and heating needs, leading to indoor air pollution. Nearly half of the global pneumonia deaths in children under the age of five, and over 1 million deaths from chronic lung diseases (mostly among poor women), are attributed to indoor air pollution. Dirty cook-stoves also produce powerful short-acting greenhouse gases that cause climate change. Also, a global increase in livestock consumption is a driver of deforestation, methane (another powerful greenhouse gas) and fatty diets.

12.2.2 Environmental exposures

Environmental exposures are a significant contributor to NCDs, including cancer. For example, 28% of coronary heart diseases have been attributed to living in proximity to polluted roads in ten European cities (3). The International Agency for Research on Cancer (IARC) has recently classified diesel exhausts as carcinogenic to humans (4). Physical activity is influenced by urban land-use patterns and transport policies which can promote cycling and walking for transport by developing safe infrastructure, as well as fostering the establishment of accessible green spaces for leisure-time physical activity and encouraging behaviour modification. Regular cycling was associated with a 30% reduction in total mortality in cohort studies carried out in Copenhagen (5) and Shanghai (6); and a meta-analysis estimated that walking behaviour reduced total mortality by 20% (7). These estimates relate to approximately 30 minutes of regular cycling or walking, a dose compatible with transport patterns in urban areas across the globe and aligned with WHO recommendations for levels of physical activity in the adult population (8). Land use affects access to fruits and vegetables, and can create food deserts; as well as provision of outdoor spaces where children can play unsupervised, which are essential for child development (9, see also Chapter 6).

12.2.3 Environmental pollution

Environmental pollution is another important contributor to health inequalities between and within countries. People from lower socioeconomic groups very often work or live in more polluted environments where housing is cheaper; closer to areas with more road traffic (hence more exposed to air pollution, noise and risk of injuries); in lower quality dwellings (hence more exposed to indoor pollutants such as moulds, mildew or unsafe fuels for domestic combustion); and in proximity to contaminated areas (e.g. polluting industrial sites, poorly operated landfills). Large inequalities in health and health burdens between countries (10, 11) are due to differences in access to clean water, sanitation, clean energy, air quality or protection from exposure to chemicals. These reflect socioeconomic differences and related access to infrastructure, safer and less polluting energy, agriculture and production technologies. For example, up to 58% of health clinics in some sub-Saharan countries lack reliable access to energy thereby limiting the cold chain, night-time births or the use of microscopes for diagnosis (12).

12.2.4 Health's role in the environmental movement and related politics

Environmental awareness has its origins in the realization that pollution causes disease: water, sanitation and housing conditions in the nineteenth century causing cholera and other infectious diseases; swamps leading to high rates of malaria had to be drained before construction of the Panama canal in the early twentieth century; and large impacts on mortality from air pollution in cities (e.g. London fog) and industrial areas (e.g. Sonora USA) in the mid twentieth century. The occurrence of major accidents – for example, the Seveso (1976, Italy) and Bhopal (1984, India) dioxin contaminations; Chernobyl nuclear accident (1986, Ukraine); and the Baia Mare (2000, Romania) cyanide contamination of the Danube river – greatly contributed to increase public and policy-makers' awareness of the environment and health risks and potential transnational impacts of certain activities. This sparked interest in regulatory systems, international collaboration, research and practice in risk assessment and management. The knowledge about health impacts led to targeted policies (e.g. water and sanitation interventions, clean air acts, chemical safety legislation) to abate health hazards. For example, the Seveso accident resulted in widespread population exposure to dioxins released by a chemical plant manufacturing pesticides and herbicides, prompting the EU to embark on new legislation aimed at the prevention and control of such accidents. The resulting Seveso Directives now apply to around 10 000 industrial establishments that use or store large quantities of dangerous substances, mainly in the chemical, petrochemical, storage and metal refining sectors (13).

The environmental movement emerged in the 1960s, spurred by Rachel Carson's *Silent Spring*. Centred around the impact of pesticides (particularly DDT) on animal and human health, the book opens in a community where their widespread use means that all birdsong has ceased. Ecology is articulated as a 'subversive subject': a perspective that cuts against the grain of materialism, scientism and the technologically engineered control of nature. The chemical industry response also centred on health arguments, claiming that DDT was essential to malaria control. This debate subsequently led to the development of integrated vector management strategies as an alternative to DDT, and of the Stockholm (14) and Basel (15) conventions to regulate the use and transport of hazardous chemicals. Other consequences included the growth of green parties and politics and development of environmental legislation and of environment ministries tasked with both controlling pollution and protecting the natural environment.

Scientific findings about the hole in the ozone layer in the 1970s, and subsequently about climate change caused by atmospheric pollutants from

human industrial activity and combustion of fossil fuels, were focused more on nature and the planet than on the associated health impacts. The health community was responsible for investigating and demonstrating the health consequences: the hole in the ozone layer leads to higher exposure to UV radiation with impacts on cataracts and the immune system; climate change causes changes in the patterns of disease and nutrition through extreme weather events (for example, heatwaves lead to increased cardiovascular mortality), changes in disease vectors, drought and floods. Even more important is the recent acknowledgement that climate change response measures have very significant impacts on health and that some climate-friendly policies are much better for health than others (16). Failure to identify the health implication of climate response measures can cause social costs. For example, the Intergovernmental Panel on Climate Change (IPCC) CO_2 reduction policy recommendation concerning use of diesel for transportation does not only substantially increase the risk of heart and respiratory disease (17) – diesel is also a carcinogen (4).

12.2.5 Aligning actions in health and environment

Politically, environment and health actors converge on the need to address environmental risks created through human influence. However, there is not always agreement on the policy options required. Some environmentalists consider a focus on the impacts on humans (an anthropocentric focus) to be detrimental to the broader environmental agenda. There is agreement on addressing pollution and related disease but hesitation on including social and behavioural risks (e.g. injuries, sexually transmitted diseases). For example, environmental impact assessments tend to consider pollution-related diseases but exclude other risks to health. Also, the IPCC has not considered the health impacts of its proposed measures to reduce climate change. This tension can be constructive and has led to progress: for example, the next IPCC recommendations are expected to refer to health co-benefits of policies to mitigate and adapt to climate change.

The notion of environmental and, particularly, ecosystem services (including how these contribute to human health) is also being advanced. There is a focus on biodiversity and its contribution to the development of medicines, and on climate resilience and how it protects humans from natural disasters (18).

Overall, the connection between environment and health is important for environmentalists. Health impacts bring a human dimension to environmental impacts: the former are easily grasped by all while some environmental concepts may seem abstract to some audiences. The dynamics of the cooperation between environment and health are shown clearly in the United Nations Conference on Environment and Development in 1992. The report of the conference

characterized competing and sometimes conflicting development objectives in the three pillars of sustainable development (environmental, social and economic) and identified the need for trade-offs to be addressed openly. Health was considered to be at the centre of sustainable development and linked to the three pillars (19). Environmental health has focused on making connections with environmental issues and with the sectors that generate them, in the absence of formal links across sectors. Its rich history is illustrated below.

12.3 Tools and mechanisms for addressing health and environmental issues emerging in the context of sector policies

12.3.1 Policies and measures to support environmental HiAP

A variety of policy instruments have been used to address environmental issues at different stages of policy development, implementation and monitoring. Examples of applications of these policy instruments and how they included health are given in the following section.

High-level political declarations

Though not legally binding, these international governance mechanisms allow for shared policy agenda setting and cooperation between health and environment sectors. These mechanisms have been in use for over 20 years: regional ministerial conferences are held regularly in three WHO regions, involving all countries in Europe (since 1989) (20) and in Africa (since 2008); and 14 countries in Asia (since 2004). WHO Region of the Americas held one such meeting in 2009. Between conferences, committees comprising representatives of these ministries follow up and monitor implementation of agreed commitments. The international agencies (on environment, health, development) and NGOs participate in the follow-up process to implement decisions made by Member States at the conferences.

Long-term cooperative action programmes

Developed from the high-level political declaration process, long-term cooperative action programmes across sectors include the Transport, Health and Environment Pan-European Programme (THE PEP) (21). This has led to networking and exchange of good practice as well as joint time-limited initiatives such as the development of tools to quantify health impacts of transport and model expected health benefits from investments in transport infrastructure: Health Economic Assessment Tool (HEAT) for cycling and HEAT for walking (22, 23).

Norms and standards

Environmental health is essential for environmental policy-making. Evidence about health effects of environmental degradation, air pollution, water contamination, noise, chemical and radiation exposure levels are developed by the health sector and often form the basis for national and international norms, standards and legislation. Levels of environmental quality that are safe for health are often used to inform allowable emission thresholds in countries. For example, the European Commission has used WHO guidelines on drinking-water quality, air quality and noise as a basis for developing the relevant European Directives. Their implementation falls mostly under the responsibility of sectoral ministries other than health (24). Similarly, environmental instruments such as emissions monitoring systems play a key part in implementing controls over environmental exposures that are harmful to health and to health protection.

Multilateral environment agreements

Environmental health contributes to the implementation of binding and non-binding multilateral environment agreements related to sound management of chemicals. For example, the elimination of asbestos-related diseases recommended by the World Health Assembly Resolution Workers' Health: Global Plan of Action (25), is being implemented in the context of the Rotterdam Convention (26) and the Strategic Approach to International Chemicals Management (27). Work to reduce reliance on DDT for disease vector control (particularly for malaria) is developed in the context of the Stockholm Convention with regional projects funded by the Global Environment Facility. In Europe, the Protocol on Water and Health to the 1992 Convention on the Protection and Use of Transboundary Watercourses and International Lakes (28) is the first legally binding instrument promoting access to safe drinking-water and sanitation. The Convention on Long-Range Transboundary Air Pollution (29) provides international cooperation mechanisms for monitoring air pollution and assessing its health impacts. The Basel Convention (13) is an example of a legally binding multilateral environment agreement set up to minimize illegal movement of toxic and carcinogenic substances between countries (see Case study 12.1).

Case study 12.1 *Probo Koala incident in Côte D'Ivoire and the need for legal obligations in multilateral environment agreements*

Multilateral environment agreements such as the Basel Convention provide an important framework and instrument for environment and health risk management, both internationally and nationally. The Probo Koala incident in the Côte D'Ivoire (2006) provides an example of the need for, and potential effectiveness of, such instruments.

The Probo Koala was a shipping vessel loaded with hazardous waste generated from rudimentary treatment of petroleum waste. Following unsuccessful attempts to offload this highly toxic cargo in several countries (including the Netherlands, Estonia and Nigeria), the ship travelled to the Côte D'Ivoire. There the materials were offloaded, illegally transported and disposed of in multiple municipal waste sites around Abidjan. The environmental and human health impacts that ensued drew considerable international attention and local protests that prompted a change in government. More than 17 people died and thousands suffered from various health problems associated with exposure to chemicals found in the waste.

This incident triggered an international review of the effectiveness of the Basel Convention and revealed some weaknesses in the framework that, had they been strengthened, could have averted this disaster. One key lesson was the need for the Convention to include a legal obligation requiring countries to notify other countries of the possibility of the arrival of ships containing illegal and hazardous substances. As required under EU law, the Netherlands had notified Estonia about the Probo Koala but no further notification took place.

Source: Eze, 2008 (30).

International Health Regulations

International agreements related to environmental emergencies also offer an opportunity for HiAP and cross-sectoral policy-making, and are now within the remit of the International Health Regulations (IHR) (31). Initially an infectious disease preparedness and response framework, the IHR has been expanded to include chemical and radiological events of international public health concern (32). This broadening of the mandate resulted from the realization that industrial accidents are becoming more frequent, particularly in rapidly developing economies, and that traditional outbreak response approaches alone are no longer sufficient. Outbreak investigation aims to unravel the sources of environmental contamination and the process and circumstances that led

to the outbreak. It also has the potential to trigger broader discussion about health in the sector policies associated with that event (e.g. if an industrial incident), going beyond the treatment of affected individuals and immediate compensation or remediation. These opportunities are not used often due to lack of capacity and focus in the health sectors. Recent examples include poisoning from recycled batteries causing 18 deaths in children in Senegal and the death of 400 children from heavy metals exposure in artisanal mining in Nigeria (33).

Litigation over environmental contamination

Environmental NGOs regularly use legislation to draw public and government attention to issues. After years of trying to raise attention with scientific arguments (it was then run by scientists), the Natural Resources Defense Council (NRDC) in the United States of America teamed up with lawyers to bring high-profile court cases which were effective in gaining greater visibility for environmental issues. For example, in 2007, NRDC and partners won an historic Supreme Court ruling (Massachusetts v. EPA) which classified global warming emissions as "pollutants" under the Clean Air Act and granted authority and responsibility for regulating those pollutants to the Environmental Protection Agency (34). More recently, environmental NGOs in India and China have used the same strategy. In India, for example, this has led to a Supreme Court decision mandating cleaner fuels for buses (35).

Actions by American companies in other countries can be brought to the American courts. Civil society groups used this approach to argue for environment protection from oil and mining companies in developing countries (e.g. Ecuador). Such high-profile court cases use evidence on environmental contamination and of related environmental health impacts. In countries with a well-articulated public complaints function such as Brazil's Public Ministry, evidence on health impacts is often used as the basis of argument when environmental cases are brought to these courts. Other well-known examples include litigations concerning environmental exposure to asbestos, a carcinogen associated with mesothelioma. Over the years, many trials have taken place across several countries. For example, in 2012 an Italian court sentenced two officers of a Swiss company to 16-year prison terms *in absentia* for the deaths of about 2000 workers who were found to have been exposed to asbestos (36).

Enforcement and effectiveness of the policy measures described

Each multilateral environmental agreement has its own reporting mechanism and incentives for compliance (finance/support for pilot projects, capacity building, development of tools, meetings of parties). Transgressing national

or regional (EU) legislation can also lead to financial or other penalties (see Chapter 5). Measures to enhance transparency and access to information, public participation and access to environmental justice, include a multilateral environmental agreement (the Aarhus Convention) developed in Europe and now being considered by other regions. The justice system is invoked by individuals, civil society or groups affected by pollution or environmental change including, for example, indigenous communities. Civil society and the media have played proactive roles in making use of the above instruments, inspiring them at times and encouraging accountability.

Health arguments and evidence of health impacts often form part of a justification for action or a basis for compensation. The degree to which health is mainstreamed into environmental decisions is dependent on available evidence, effective articulation of the health aspects/issues and grasping opportunities opened by environmental debates and decisions of health or other social actors. Measures and tools that have been effective in mainstreaming health into environmental decisions are described in the following section.

12.3.2 Tools to raise awareness of the importance of health in environmental decisions

Awareness of environmental pollution

Awareness of environmental pollution can trigger work on the root causes of pollution and disease in other sectors. For example, there is now widespread understanding and concern about air pollution and its health impacts. This was not always the case, but scepticism has faded in the face of the preponderance of solid environmental epidemiological information coupled with good monitoring of air pollutants in urban areas in different parts of the world. Also, actions by civil society organizations raise awareness and help to articulate city and country-level action for prevention of air pollution and its health impacts (37).

Economic assessments of the impacts of environmental health problems

Estimates of the impacts and external costs that policies impose on the environment have been widely used and draw heavily on health information. Studies on the external costs of policy options (e.g. ExternE – the External Costs of Energy (38), comparing life cycle analyses of fuel cycles) identify health costs as among the largest. Health has been included unevenly in environmental economics analyses but, when it is included, is often the largest cost in externality assessments. For example, as shown in some of the early cost of environmental degradation studies conducted by the World Bank in Lebanon and Tunisia (39).

Health impacts associated with air pollution (both indoor and outdoor) and with lack of access to adequate water and sanitation were the two largest socioeconomic costs found to be associated with environmental degradation. This may underestimate the actual health costs as it reflects mainly the health costs of environmental determinants of health, leading to a policy debate on what counts as externalities and how impacts should be modelled. For example, of 13 studies on the costs of inaction on climate change only the Stern report (40) made some reference to health issues. The IPCC's latest analyses comparing the cost effectiveness of policies aimed at achieving reductions in CO_2 in different sectors of the economy largely ignored health. However, analyses of health co-benefits from climate mitigation by the health sector are likely to be included in the next IPCC report. The debate around improving the assessment of transport externalities by better inclusion of health effects resulted in the development of new methods and tools for European countries (41).

Estimates of the environmental burden of disease

The increased capacity to estimate the fraction of the burden of disease attributable to environmental causes plays a very important role in estimating the magnitude of exposures and their related health effects. This substantiates the call to action and facilitates understanding of the importance of environmental health in relation to other health risks. It can also support improved understanding of the links between NCDs and the environment, highlighting important opportunities for primary prevention of cardiovascular and respiratory diseases, cancer, diabetes and overweight through environmental interventions that improve the quality of the working and living environments. Overall, one quarter of the global burden of disease is estimated to be preventable through environmental interventions (42).

12.3.3 Mainstreaming health into policies, plans and projects through health impact assessment

Lessons from implementation of environmental impact assessments

Lessons from implementation of environmental impact assessments informed the early development of health impact assessment. Firstly, there was a realization that performing such assessments on a project-by-project basis limits understanding of the overall/cumulative impacts of an industry (i.e. impacts of multiple projects in a given area) as well as subsequent decisions on impact management options. At the same time, policies and strategies define what and how projects will be developed in the future so environmental impact assessments of policies and strategies seem to be an efficient way to

address some of the limitations of environmental impact assessments applied to individual projects. This led to the development of strategic environmental assessments which operate on policies, plans and strategies rather than on individual projects.

Secondly, environmental impact assessments evolved from a focus on nature/biological impacts to acknowledge gradually the need to consider social context and impacts, and the subsequent development of methods and tools for social and other types of impact assessment. Similarly, health impact assessment has evolved from a focus on biophysical risks to include social and occupational determinants of health.

Thirdly, the legal requirement for environmental impact assessments is now found in most countries of the world, together with the mechanisms to oversee/ensure implementation. This has led not only to the implementation of environmental impact assessments in specific projects, but also to wider understanding and acceptance of the need to consider environmental issues when developing a project – that is, helping to mainstream environment into sector policies and projects. Often, human health is formally within the scope of what environmental impact assessments should consider but receives only limited coverage (43). Strengthening of the health assessment component of environmental impact assessments will open an opportunity for HiAP.

Evolution of health impact assessment in relation to environmental impact assessment

Larger-scale application of **health impact assessment** was driven initially by the need to control vector-borne diseases through non-chemical means in large irrigation and water projects. A WHO/FAO/UNEP Panel of Experts on Environmental Management for Vector Control (PEEM) was created in 1981 to develop institutional frameworks for intersectoral and interagency collaboration. Methods were developed to forecast diseases in water management projects (44). Established in the 1990s, the World Commission on Dams expressed concern over health impacts of water projects and, in cooperation with WHO, included health impact assessments within its deliberations (45).

The health sector has contributed to the integration of health within the new Protocol on Strategic Impact Assessment of the United Nations Economic Commission for Europe (UNECE), which came into force in 2010 (46). Health sector experience of environmental and social determinants of health, and on health impact assessment for healthy public policies, informed negotiations on the text: the final version includes a broad health perspective and makes health a key part of strategic environmental assessments. For example, the Protocol specifies when and how to consider health at different stages of the assessment

process; the need to consult health authorities; and to consider health goals (47).

This experience contributed to the WHO Department of Public Health and Environment's subsequent change in focus towards strategic health impact assessments. Again, this was driven by the realization that strategic environmental assessment alone rarely provides sufficient depth to allow adequate coverage of human health impacts. A period in which WHO focused on capacity building in countries, and developing guidance on health impact assessment, has been followed by a focus on health impact assessment of strategies identified as being of political importance, with large potential for public health benefits and in which health was neglected to a large extent. This included the *Health in a Green Economy* series of analyses, and strategic health impact assessment applications in the extractive industry and in the context of development lending as described in Box 12.1 and 12.2 and Case study 12.2. In each application, strategic health impact assessment activities focus on the health impacts of sector policies or strategies, and make high-level recommendations on how to manage risks and enhance health gain across the industry. In some instances (e.g. the extractive

Box 12.1 *Health in a green economy*

WHO has used health impact assessment to assess the co-benefits and risks of national/local-level policies to mitigate climate change proposed in the last IPCC assessment report. The panel reviewed mitigation policies for housing, transport, agriculture, household energy and health-care sectors. Impact assessment of these policies estimated that some have negative health impacts: for example, use of diesel fuels to reduce CO_2 in the transport sector is expected to increase fine particulate matter (PM10) air pollution and cause respiratory and heart disease. Others, less prominent in the IPCC review, had large health co-benefits: for example, the promotion of rapid bus transit systems coupled with infrastructure for safe cycling and walking (49) as used in Bogota and other developing country cities.

The analysis also identified the IPCC-proposed policies expected to provide the largest health equity benefits, such as recommending more emphasis on buildings' energy efficiency in slum areas. For example, building insulation and solar water heaters in South African slums (50) had been deployed in exchange for carbon credits. The WHO report illustrates how to marry climate mitigation and health equity objectives to benefit the poor (51). WHO concludes by calling policy-makers and stakeholders to use health impact assessment to identify health co-benefits in sectoral and national policy-making for climate change, not only because health is a societal goal in itself but also because health and health equity gains tend to be local and to occur soon. In this way they benefit those contributing to the climate policies, while the gains from CO_2 reductions are diffuse and occur many years later.

industries' examples) health-system strengthening components have also been built into the strategic health impact assessment model. The perspectives and potential contributions of government, industry and public health actors are specifically addressed (48).

Box 12.2 *Need for strategic health impact assessments in the extractive industries*

Natural resource extraction can be a key driver of development. Yet, many countries have been unable to harness this potential and have instead been plagued by the 'resource curse' – where oil or minerals neither benefit local populations nor lead to economic growth. Rapid population immigration can also affect communicable disease patterns (e.g. sexually transmitted diseases, HIV/AIDS) and increase social tensions – which can result in mental health problems, increased violence and increased alcohol consumption – among those living in proximity to extractive industry operations, including poor women and children. The industry often contributes to address certain health issues (e.g. vectors, HIV/AIDS) but does not engage with the full range associated with its activities – many of which end up posing a risk to the community and, potentially, the project. This is driven partly by the perception that responsibility for population health rests with the respective host country authorities, and not with industry; partly by the fact that very few countries require project proponents to carry out health impact assessments. Hence, those impact assessments that are conducted do not always adequately capture the full range of community health issues.

First results show that strategic health impact assessments (i.e. applied at the level of industry or whole of sector) can help to establish a 'social accountability' framework for use in monitoring and measuring the net social value (measured in terms of health gains or losses) generated as a result of investments made to develop a country or region's mineral and fossil fuel resources. Strategic health impact assessment can also catalyse investment in strengthening country health risk management systems (e.g. chemical incident surveillance and response capacities) that include participation of the government, the development community and the private sector (industry operators). It can also allow identification of multiple projects' cumulative effects on health and health systems which are not normally captured by project-level health impact assessments.

Case study 12.2 *Multilateral financial institutions as entry point for environmental, social and human health protection: the example of Mongolia*

In 2007, WHO began cooperating with several multilateral financial institutions (e.g. The World Bank, Regional Development Banks) to support greater coverage of public health issues as part of their environmental and social safeguard policies and practices. Multilateral financial institutions

Case study 12.2 *contd*

often require projects to conduct a series of impact assessments to demonstrate compliance with performance requirements for a range of environmental and social issues including biodiversity and ecosystem services; pollution prevention and control; indigenous people; involuntary resettlement; cultural property/heritage; and occupational health and safety. In 2006, the International Finance Corporation (IFC) adopted a new performance requirement for community health, safety and security. This triggered greater interest in exploring how to integrate health more broadly into multilateral financial institutions' safeguard systems: for instance, using health impact assessment. For WHO, this interest and cooperation offers a major opportunity to reduce threats to public health in other sectors. By mainstreaming health considerations into non-health-sector investment and development activities, prevention activities can be directed at the source(s) in which these threats to health originate. This includes large public and private sector investments in developing countries, such as natural resource extraction (oil, mining, forestry), infrastructure and tourism.

The multilateral financial institution safeguards offer an important entry point for environmental and social (and human health) protection, particularly in contexts where domestic legislation and national capacities for environmental and social assessment, and for public participation and access to grievance/environmental justice, are weak. These requirements also offer important opportunities for potentially affected communities and civil society organizations to participate in the decision-making process for these large-scale investments and to voice complaints and grievances over non-compliance with the implementation of environmental and social protection measures. These performance standards can also influence national standards, even in relation to the coverage of health within environmental assessment. For example, the construction of the Oyu Tolgoi mine in Mongolia's southern Gobi desert: the largest and most ambitious gold and copper mining project in the world.

The health impact assessment of Oyu Tolgoi was the first to be undertaken in Mongolia (52). It was commissioned by Rio Tinto, the mining operator, in order to secure financing from the IFC, the private sector lending arm of the World Bank Group. Several donors and development partners (including WHO and the Governments of Australia and Canada) had been supporting health impact assessment capacity development initiatives (i.e. training) since 2009.

Design and implementation was based on health impact assessment models developed by the International Council on Mining and Metals (ICMM)

Case study 12.2 *contd*

(53) and by the IFC (54). Both these models are widely considered (by industry) to be good practice models but the Ministry of Health quickly determined the need to develop its own national standard for mining projects. Draft guidelines for health impact assessment of Mongolia's mining sector were produced in 2011, with support from WHO and a group of Canadian specialists from Simon Fraser University.[1]

1 Janes C, Team Leader, Simon Fraser University Project, personal communication, 2012.

12.3.4 Mechanisms to create transparency and accountability

Monitoring and evaluation

Environmental health indicators make the connection between a determinant of health in another sector and health risks, or related ill-health. For example, the annual Global Analysis and Assessment of Sanitation and Drinking-Water (GLAAS) and WHO/UNICEF Joint Monitoring Programme for Water Supply and Sanitation (JMP) (55) assessments report on investments in water and sanitation infrastructure, and on exposure to related risks to health, on a regular basis. This provides a measure of progress in achieving the related MDG targets on water and sanitation, in terms of policy actions being taken and resulting improvements in drinking-water supply and sanitation. The identification of water and sanitation as an MDG target, and therefore indicator, has meant resources have been allocated for this monitoring. Conversely, air pollution is now estimated to create a much greater burden of disease but monitoring and evaluation efforts have not yet incorporated the breadth of causes and impacts. A range of environmental actors/agencies (e.g. EEA, UNEP, OECD) develop environment outlook reports with trends and forecasts but the health sector has not yet fully utilized these opportunities. The possible exception is water and sanitation which may be because efforts to address health hazards in water have a longer history and/or because of more immediate and visible health gains.

Establishment of additional environmental health sustainable development targets (such as for air pollution) would enable generation of better evidence about the impacts of specific sector policies and allow better monitoring and evaluation efforts (e.g. as part of a HiAP approach). For example, in the European Region, the Parma Declaration on Environment and Health (56) resulted in the adoption of five time-bound targets related to air quality; water and sanitation; promotion of safe physical activity; chemical exposures in pregnant women and children; and asbestos-related diseases. WHO is following up that commitment by working with European Member States to develop an

information system for monitoring and reporting on progress towards these targets (57).

Access to information, public participation and access to environmental justice

Closely related to mechanisms to ensure monitoring and evaluation, transparency and accountability have been key to the progress and success of environmental goals. There has been a growing movement for access to environmental justice, access to information and more emphasis (globally) on public participation. The Aarhus Convention on Access to Information, Public Participation in Decision-making and Access to Justice in Environmental Matters, has been ratified by 41 countries. The compliance mechanism allows members of the public to communicate related concerns directly to a committee of international legal experts empowered to examine the merits of their case and make recommendations to the meeting of the Parties. The Aarhus Convention (58) is a landmark, developed in Europe and now being replicated in other parts of the world.

Mass media and civil society organizations

With the latter including individuals and groups affected by pollution or environmental concerns, these have played a major role in identifying health and environment issues, pressing for preventive/corrective action, monitoring results and invoking access to justice. As described in the introduction, they have shaped the environmental movement but it is beyond the scope of this chapter to examine their role in detail. For example, the Women in Europe for a Common Future (WECF) is an NGO comprising an international network of over 100 women's, environmental and health organizations implementing projects in 40 countries and advocating globally for a healthy environment for all. Active internationally concerning water and sanitation, WECF represents civil society in the UNECE/WHO Protocol on Water and Health process and advocates for an integrated and sustainable approach to water resource and river basin management. This NGO implements decentralized, safe, sustainable and affordable sanitation systems in rural areas and particularly promotes access to safe water and sanitation for schools. WECF raises awareness and mobilizes citizens to achieve sustainable water and wastewater management and promotes community-based and affordable water supply systems for rural areas lacking a centralized drinking-water supply (59).

Mechanisms to enable cross-sectoral collaboration

Whether at international or national level, the creation of enabling platforms is key for bringing together the environment and health sectors on an equal footing.

The importance of effective systems to facilitate this cannot be overemphasized. The legitimacy and mandate to act – as well as the definition of appropriate lines of authority and the attribution of responsibilities and resources – are the pillars on which intersectoral policy action rests. These have proven challenging to develop and maintain, particularly in the face of economic crises which work against the necessary spirit of sharing information, competencies and resources. For example, at international level, the collaboration between WHO (with convening powers for health ministries) and UNECE (with convening powers for environment and transport ministries) has been a prerequisite for bringing together the three sectors under the policy platform established under THE PEP. As part of THE PEP implementation, a project reviewed examples and practice in developing integrated policy approaches for transport, environment and health in different countries (60).

12.4 Experience of integrating health into environmental assessments: lessons for HiAP

Environmental impact assessment is one of the main instruments used to mainstream sustainability considerations into development policies, plans and projects. Most countries of the world have legislation requiring such assessments and related mechanisms to oversee/ensure their implementation. Human health is often within the formal scope of what environmental impact assessments should consider and strengthening of this component offers an opportunity for HiAP.

Lessons learned from addressing health through (or in parallel with) existing environmental assessment instruments provide some insights into enabling/institutional factors that would also be relevant for HiAP.

- The definition of health used in environmental assessment laws, regulations, or policies needs to be clearly defined and needs to be broad and inclusive of environmental and social determinants of health. In the absence of this clarity, coverage of health within environmental impact assessment practice varies according to the way in which health is interpreted (i.e. narrow or broad conceptualization of health and its determinants). For example, health is acknowledged as an important and relevant issue but is not considered automatically in the impact assessment process (61). A study evaluating how health issues were treated and presented in 28 environmental impact assessments for road projects in Sweden concluded that health consequences were limited to those where pollution limit values exist, and there had been no presentation of the affected population (62).

- Coverage of health issues needs to be mandated within the environmental impact assessment process. This is key to fostering common understanding of how health should be addressed (i.e. what should be included) and to ensuring that health issues are considered at the right moments in the process.
- Clear specification of the impact assessment process (i.e. how it will be done) is essential for ensuring that health issues are included systematically. Existence of a formal procedure will also build capacity and institutional memory that will help to reinforce the inclusion of health issues in other areas/impact assessments. The multilateral financial institutions have well-articulated operational policies for this process, providing a useful model for health impact assessment and HiAP purposes.
- A dedicated entity (e.g. intersectoral working group, committee or unit) should carry responsibility for engaging in (or overseeing) the impact assessment process. Whether regulatory or facilitative, these functions cannot be sustainable unless they are formalized and supported with budgetary and human resources.
- A body with responsibility for continuous learning and capacity development (e.g. training, research or academic institution) is also important for ensuring institutional memory related to the use of impact assessment methods and processes. It is also helpful for building and maintaining a continuous pool of experts able to engage effectively in such activities (e.g. local cadre of qualified impact assessment practitioners).
- Requirement for a functioning system to monitor and report expected and actual health impacts. Also, whether mitigation measures proposed for the project/policy have been implemented and with what results. This can facilitate independent evaluations of the effectiveness and/or impact of the impact assessment process and is a critical component of accountability that can serve two purposes: (i) ensure compliance with the delivery of required impact mitigation measures; and (ii) monitor integrity of the process.

The development and use of accountability frameworks has progressed significantly within environmental assessment. The following are some typical elements found in effective accountability mechanisms.

- Mechanisms for public disclosure of information about the impact assessment process and related impact management activities: these are normally reinforced by an access to information policy.

- Process (and requirement) for public consultation and participation: for example, within stakeholder engagement activities conducted during the impact assessment.
- Grievance mechanism: allowing affected communities and individuals to voice complaints or concerns about the policy or project once it has been implemented.
- Independent evaluation function: as previously described but able to be invoked in response to a community complaint/grievance and designed to review the integrity of the impact assessment process or resulting environmental and social management plan, and compliance with their own policies, goals and objectives.

While environmental assessment offers an important entry point for including health in development policies and decisions, a range of internal and external factors influence the effectiveness of this mechanism for HiAP (as for other entry points such as health impact assessment). Examples of internal factors include lack of health experience and of technical capacity for the use of health impact assessment among impact assessment specialists (many are environmental and/or social specialists) as well as institutional barriers between specialist areas. As an institutional function environmental health is often fragmented and caught between environment and health authorities, neither of which considers it to be their core business.

In the context of environmental assessment, the ministry of environment is usually the responsible government authority. If health issues are to be addressed by using environmental impact assessment as an entry point, the quality of coverage of health within this is often determined by the effectiveness with which the health ministry is able to engage in and influence a process that is not formally within their remit or responsibility.

In many countries, environmental impact assessment and strategic environmental assessment are mandated by legal requirements but health impact assessment often occupies a rather blurred regulatory situation. This presents an additional important limiting factor, resulting in uncertainties about, inter alia: procedures to follow; assignment of responsibility for initiation and evaluation; or costing and recognition of the value of the assessment. This may result in an overall lack of support for health impact assessment, and uneven use of the tool for informing policy decisions.

Private interests can often perceive procedures that impose restrictions and/or additional costs (e.g. to mitigate or prevent possible adverse health effects) to be hindering or delaying possible opportunities for economic development. At times of financial crisis, there is a growing risk that such procedures are rejected

in favour of economic and social development objectives. This is exemplified by the emergence of potential societal conflicts over possible trade-offs between protection of employment opportunities and health, and by policy approaches that tend to prefer voluntary action by industry rather than legally binding regulatory measures.

External economic interests also often play against effective policy action: extractive industry projects in developing countries provide clear examples of this. Government interest in rapid advancement to higher income status often leads to overestimation of the possible short-term economic gains and underestimation of the long-term environmental, health and societal costs often associated with such operations. The Chad-Cameroon Petroleum Development and Pipeline Project clearly illustrates this complexity (Case study 12.3).

Case study 12.3 *Short-term economic gain versus long-term environmental impacts in Chad*

The Chad-Cameroon Petroleum Development and Pipeline Project is the largest public/private oil and gas development project to be implemented in sub-Saharan Africa. At a total cost of US$ 6500 million (63), this project remains the most ambitious and most contentious extractive industry project ever supported by the international development community. This was to be a major opportunity and model for poverty reduction, and was expected to be the first example of how to beat the 'resource curse' commonly associated with oil in the developing world.

For Chad, oil was the most important and rapidly developing economic sector. In 2004, 33% of Chad's gross national product was generated by the oil industry. By 2007, this figure had risen to 46.9% (64, 65).

The World Bank intended this to be a model project for the extractive industries. For the first time, its loan agreement with the Government of Chad required the development of an oil revenue management plan which would, among other provisions, establish a legal framework. The Petroleum Revenue Management Law (1999) required the majority of royalties and dividends from oil production to be earmarked and spent on poverty reduction through priority sectors such as health, education and infrastructure, and 10% of proceeds from oil sales to be set aside in a fund for future generations in the post-oil era (66).

In December 2005, claiming that it faced both a financial and a security crisis, the Government of Chad unilaterally amended the Petroleum Revenue Management Law in order to increase its access to revenues for discretionary

Case study 12.3 *contd*

use. Key provisions in the law, including the Future Generations Fund, were removed (64).

The World Bank withdrew from the project in 2008.

By 2009, Chad's government revenue from oil was almost US$ 4.4 billion – 17 times the amount projected and almost double non-oil revenue from all sources. The World Bank's Independent Evaluation Group review of the project's performance reported that the oil revenue windfall was associated with a resurgence of civil conflict and overall worsening of governance.

Some of the measures described could be used to address internal factors: for example, articulation of well-defined policies and procedures to support intersectoral activities around the environmental impact assessment process. However, the question of how to address wider economic and political factors (for example, those influencing the revenue management plan in Chad) is far more complex and warrants a discussion that certainly extends beyond the scope of this chapter.

As previously described, environmental impact assessments are well-accepted and legally required in most countries, presenting a major opportunity to include adequate assessment of health impacts. Of course, independent institutionalization of health impact assessment is a key mechanism to achieve HiAP but this is beyond the scope of the focus of this chapter. Examples of stand-alone health impact assessment may be found in Quebec and Thailand.

12.5 A way forward: harnessing the opportunity for HiAP

Environmental health works across health, environment and other sectors to promote health and prevent disease through action on environmental and other determinants of health. Experience with environmental assessment; regulatory and standard setting processes at national and international levels; specific environmental health hazards; and sustainable development processes offers substantial insights into practical implementation of HiAP. Also, this shows that environmental health is a solid and important entry point for the enactment of HiAP that should be further explored. For example, current debates on sustainable development offer a major opportunity for HiAP. These include the follow-up to the 2012 Rio+20 conference and related discussions around post-MDG targets and sustainable development goals.

The health sector has a special duty to contribute to those debates, not least to ensure that policy decisions do not inadvertently undermine/reverse health and development achievements. Health can also proactively contribute to policy choices in those sectors by identifying policy options that provide maximum benefit for the environment and for human health and well-being: the win–win policy solutions. Similarly, by measuring and reporting on health and health equity metrics associated with specific sector policies (e.g. if measured as a sustainable development indicator), health can provide an important indicator of the extent to which those policies are having a positive impact on development.

Achievement of this integration requires the establishment of a framework to connect policy-making across sectors. In the context of the current sustainable development debates this could be achieved through the following measures.

- Mandating the health sector to make formal contributions to global governance processes on sustainable development, including within the context of economic, environmental and social decision-making where health plays an active role in related decisions (e.g. interagency agreement, global convention) and has responsibility for specific actions (e.g. as part of post Rio+20 processes and related processes defining sustainable development goals).
- Supporting and enhancing full implementation of existing regulatory and legal policy instruments which address environmental health issues, including multilateral environment agreements.
- Establishing sustainable development goals that adequately reflect the connections between health and development, and provide a vision for healthy sustainable development (e.g. indicators on healthy built environments, access to healthy energy sources, access to healthy foods etc).

A roadmap for embedding HiAP into sustainable development governance would include the following actions.

- Generating research on the links between sector policies, health and environment and on the effectiveness of interventions to protect and promote environmental health.
- Developing information systems that connect investment and development policy decisions in key sectors of the economy to related health risks and benefits. This involves creating connections between information systems in health, health determinants and on sector policies, for example. These systems would be used to report on the health performance of sector policies over time.

- Making wider use of health impact assessment tools at the planning stage of sector policy and investment decisions. Anticipating and mitigating health risks and enhancing potential health gains from those decisions, in connection with existing environmental impact assessment and social impact assessment systems.
- Developing guidance on healthy policy options for key sectors of the economy (e.g. housing, transport, energy, agriculture), identifying links between policy decisions and health and related measures to prevent potential health risks and enhance health gains. Guidance would need to be developed in close connection with policy actors in those sectors of the economy.
- Use of tools for including health aspects into cost-benefit analysis of decisions in key economic sectors.
- Developing capacity for the health system to access alternative finance mechanisms (e.g. environmental or carbon finance) and for including cross-sectoral goals in criteria for assessing the performance of global financing mechanisms.

The tools and frameworks to support this application of HiAP already exist. This now needs the health sector, including WHO and other health development agencies, to define a vision of 'healthy' development policies and stimulate the establishment of HiAP as a formal contribution/mechanism for global governance for sustainable development.

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Chapter 13

Making development assistance for health more effective through HiAP

Ravi Ram[1]

Key messages

- HiAP offers potential to reinforce global efforts to improve the effectiveness of development assistance for health and promote sustainable improvements in public health by incorporating social determinants outside the health sector.
- The modalities of funding and typology of actors in development assistance have evolved since their post Second World War origins, but the primary means of aid delivery has been vertical funding. Typically this is restricted to specific issues or diseases, emphasizing donor control over accountability to populations of LMICs.
- Emerging international standards for aid effectiveness provide a normative policy context for the effective application of HiAP. Capacity building in HiAP is important for enabling LMICs and their development partners to surmount technical challenges.
- There is a wide scope for mainstreaming HiAP into development assistance beyond the traditional vertical funding model given: the recognition of health as a cross-sectoral issue; existing efforts to formulate solutions at the policy and programme levels; and increased awareness of ways to accommodate divergent political interests that govern decision-making about aid.

1 The reviewers and editorial team provided very useful and much appreciated feedback on an earlier version of this chapter. Additionally, Ron Labonte and Arne Ruckert took time to shape initial discussions of the issues to be raised. All errors and omissions remain those of the author.

- The political question on aid effectiveness concerns compliance with existing agreements rather than new principles. Some progress has been seen in LMICs, but greater efforts are needed from development partners (traditional donors, international and multilateral agencies, providers of technical assistance or commodities, think tanks, public–private partnerships). HiAP in development assistance requires joint leadership from LMICs, their development partners and civil society.

HiAP must be integrated into development assistance in all sectors (not only health) in order to address global health inequities and realize health for all, including populations in LMICs.

13.1 Introduction

Effectiveness of development assistance for health has been a longstanding concern of the development community. Such concerns include the low reliability and sustainability of external funding for health; lack of policy coherence due to funders' conflicting and changing priorities; restricted funding tied to specific, narrow donor priorities; and administrative overburdening of already understaffed public institutions in LMICs.

Harmonization, donor alignment and predictability, country ownership and other aspects of aid effectiveness are thus major challenges for global and national actors. These require an intersectoral perspective; use of impact assessment tools to inform policy and practice; institutional networks supportive of policy-making and implementation; and accountable forms of global governance. Until recently, HiAP was not actively considered in this field although it offers the potential to reinforce global efforts to improve the effectiveness of development assistance for health and to promote sustainable improvements in public health by incorporating social determinants outside the health sector. This chapter describes the context of development assistance in terms of actors, aid modalities and global aid architecture. A set of considerations is proposed regarding the application of HiAP to relationships between development partners and LMICs.[2]

13.2 Overview of development assistance for health: evolution of actors

The current mix of actors in development assistance has evolved from its origins as a primarily bilateral endeavour between donor and recipient governments,

2 For simplicity, 'LMIC' refers to governments and/or populations in low- and middle-income countries. In the present discussion 'development partners' refers to the actors identified in Fig. 13.1, encompassing not only traditional donors (typically bilateral agencies of high-income states) but also international and multilateral agencies (United Nations system, other Bretton Woods institutions, EU and others at state/market or state/civil society intersections in Fig. 13.1); providers of technical assistance or commodities; think tanks; and private foundations (civil society/market intersection).

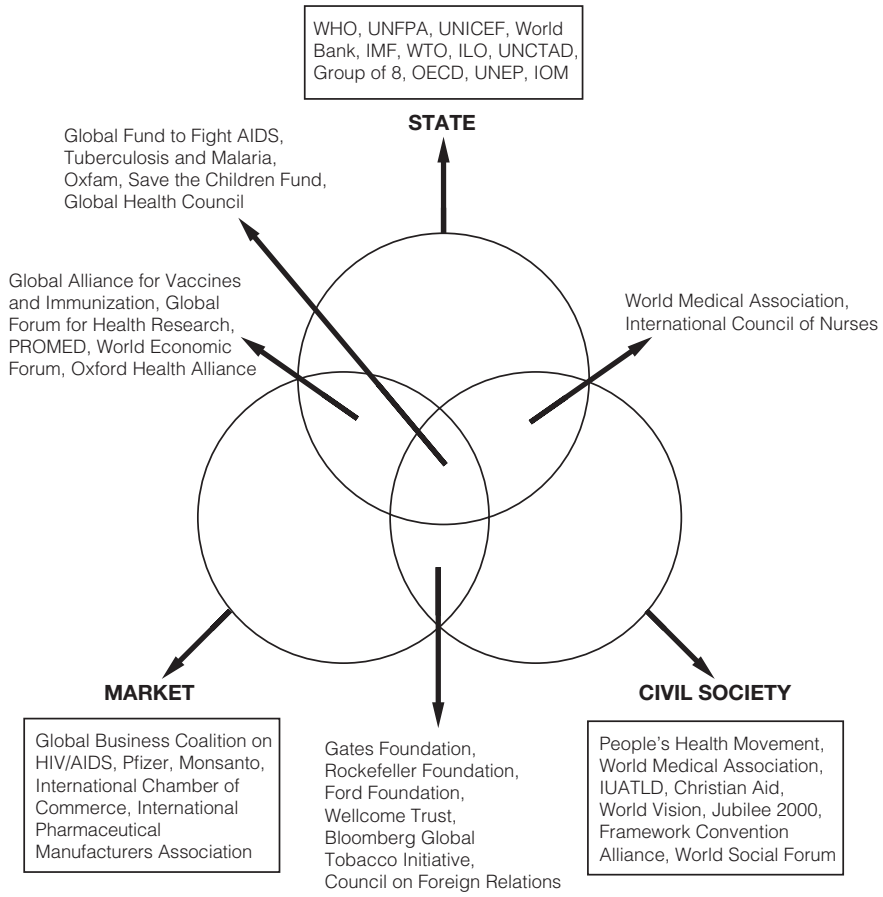
with flows from the Global North to the Global South. The current architecture of development aid began with the first meeting of the Bretton Woods institutions[3] in 1944; and establishment of the United Nations in 1945 (WHO in 1948) and the OECD in 1961. Concepts of official development assistance (ODA), other official flows and (subsequently) development assistance for health (DAH) were articulated by these initial actors in 1969 (1). There are now multiple typologies of actors, compounded by a range of different types of partnerships and other relationships. Traditional bilateral funding from donor governments has grown but the contribution of multilateral and private donors has accelerated even faster. The most prominent multilateral agency is the World Bank, which substantially increased its focus on health and other social sectors in the early 1990s. By the late twentieth and early twenty-first centuries, many observers found the World Bank's influence in health to be greater than that of WHO (2). Specific to health, other multilateral bodies include the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund). In recent years, private foundations have wielded tremendous power in both funding and influence. The Bill & Melinda Gates Foundation is the most prominent example, eclipsing even organizations with a longer history of engagement in health such as the Ford and Rockefeller foundations. It is now included in the Health 8 group of major actors in international health, along with WHO and the World Bank. The emergence of large public–private and quasi-commercial actors has also changed the dynamics of priority-setting and decision-making in development assistance.

Lee et al. (3) proposed a useful model for classifying actors in development assistance for health, based on three dimensions: the state, the market and civil society (see Fig. 13.1). Some actors can be classified in two or all three dimensions, as shown in the Venn diagram. In the past few decades, rapid growth in the numbers and types of non-state actors, in particular, has made the post-war aid architecture far more complex. Along with the redistribution of power among manifold development actors, additional recent factors create a need for greater aid harmonization and attention to sustainable impacts:

- expansion of aid flows: substantial increases in development assistance for health and for other sectors;
- funding and decision-making shifting from traditional donors to private philanthropies, with accompanying challenges from lack of public accountability;

3 Bretton Woods institutions include the World Bank and the International Monetary Fund which were set up at a meeting of 43 countries in Bretton Woods, New Hampshire, USA, in July 1944.

Fig. 13.1 *Typology of actors in development assistance for health*



Source: Lee et al. (3).

- growing focus on social determinants of health as a means to ensure and sustain health impacts; and
- globalization and market interests crowding out professional and civil society voices in health governance.

The types of development actors have been recast by the larger volumes of development assistance, along with the emergence of a global architecture of aid and emphasis on alignment with LMICs' needs and priorities.

13.3 Intersectoral experience in development assistance for health

Many development actors have already recognized a critical limitation in

development assistance for health – the health of populations is inextricably linked to a variety of social and other determinants outside the health sector. This problem is evidenced in development assistance programming in a variety of ways. In the most common form of assistance, funding is allocated to address narrowly specified diseases or health issues. This is known as stovepipe or vertical programming (4–6). For example, HIV prevention programming that ignored the gender-driven and behavioural linkages with reproductive health was not as effective as anticipated, prompting efforts to link funding for HIV/AIDS with sexual and reproductive health and rights. Similarly, recognition that the biological, social and environmental risks of HIV were conjoined with tuberculosis and malaria ultimately led to the establishment of UNAIDS and, later, the Global Fund.

It is recognized that vertical funding in development assistance can undermine health system development and exacerbate health inequities. Both technical and financial resource allocation can be biased towards treatment rather than prevention, driven by external parties rather than local needs (6, 7). Such overly specific interventions are typically driven by donor priorities. In turn, these are based on the interest or saleability of those priorities among constituents in the donor's home setting rather than the needs and relevance in the actual locus of implementation.

Vertical programming in development assistance for health continues, but there is a growing trend to emphasize horizontal programming that focuses on public health systems' capacity to address a spectrum of health needs. More recently, some have suggested a diagonal approach (8) in which funding for disease-specific programmes is integrated with health systems-focused interventions. Other types of aid include the SWAp approach in which donors agree to support public expenditures in one or more sectors (such as health) without determining specific levels of funding within each sector; and general budget support (GBS) in which development assistance is provided through a national treasury mechanism for allocation and use according to country priorities. Other specialized modalities of development assistance include debt relief, frontloading, aid in kind and advance market commitments. Of these latter approaches, aspects of debt relief can act in a similar manner to GBS and deliver comparable benefits, although monitoring of LMIC decision-making, budgeting and expenditure often brings higher transaction costs. By contrast, frontloading, aid in kind and advanced market commitments operate similarly to vertical funding. However, they have conditionalities that are not always obvious, typically favouring constituents in the donor country (particularly the pharmaceutical and agricultural industries). These various aid modalities are summarized in Table 13.1.

The tension across this typology of development assistance revolves around questions of accountability and control. The more specified or vertical forms

Table 13.1 *Modality of development assistance in relation to HiAP*

Type of aid	Implications for LMICs	Implications for development partners	Window of opportunity for HiAP
Vertical (stovepipe) funding	• Short-term focus • Aid may not be relevant • Lack of sustainability • Larger aid flows • High fragmentation and poor coordination • Highest transaction costs	• Financial and operational control and measurable attribution of results to donors • Only low level of results (outputs) is observed • Risk of dependency	None
Advance market commitments[1]	• Often tied to a specific health commodity – similar to vertical funding • Low accountability to national priorities	• Similar to vertical funding • Direct or indirect support to domestic industry	None
Diagonal funding	• Combines larger 'tied' aid flows with health systems strengthening • Synergy in aid programmes	• Harmonization of aid • Combines sustainability with clear outputs	Low
Aid in kind (e.g. technical assistance, food, commodities)	• Useful in emergencies • Undermines local markets • High transaction costs	• Supportive of donors' domestic constituencies • High visibility and attribution	Low
Horizontal funding	• Strengthened health systems • Difficulties in measurement and traceability	• Greater synergy and harmonization in aid • Greater sustainability • Rivalry among stakeholders	Moderate
SWAp	• Greater relevance and alignment of aid with national health priorities • Improved alignment • Stronger country systems • Institutional learning • Lower transaction costs	• Benefit contingent on additionality of funding • Improved partnership • Lower attribution of results and accountability • Outputs not attributable	Moderate

Table 13.1 *contd*

Frontloading (via multilateral agencies)	• Often tied to a specific health need – similar to vertical approach • Predictable aid flows within specific health area	• Requires budgeting discipline or third-party fund management • Indirect support to domestic industry	Moderate
Debt relief	• Greater relevance and alignment of aid with national health priorities • Stronger country systems • Institutional learning • Predictable aid flows • Variable transaction costs • Limited to eligible, highly indebted poor countries	• Benefits contingent on additionality of funding • Lower attribution of results and accountability • Outputs not attributable	Moderate/high
GBS	• Greater country ownership • Strengthened institutional knowledge and experience • Local accountability • Stronger country systems • Greater relevance and alignment of aid with national health priorities • Lowest transaction costs	• Lower attribution of results and traceability • Strong alignment and harmonization • Outputs not attributable • Requires multiyear commitment to funding	High

1 An advance market commitment is a legally binding commitment from development partners to purchase items, such as vaccines or drugs, that are considered missing in the market.

of aid are more likely to yield results that are measurable and attributable to the donor, even though such aid may be less effective or have more transient results. The more closely that development assistance approaches the GBS model, the stronger the potential for capacity development and institutional learning within the recipient country regarding planning, allocation and programming of resources for health, and therefore sustainable results. This also represents a larger window of opportunity for HiAP. Untying the restrictions on aid creates challenges for development partners and for LMICs: by diluting attributable results for the donor and shifting accountability towards the recipient governments, local decision-makers become responsible for meeting national health needs. Conversely, SWAp, GBS and, to a lesser extent, debt relief approaches for public health have the advantages of including expanded synergies in development assistance for health; reducing unproductive or even destructive rivalries for funding within the health sector; and providing greater opportunities to integrate health priorities into other sectors.

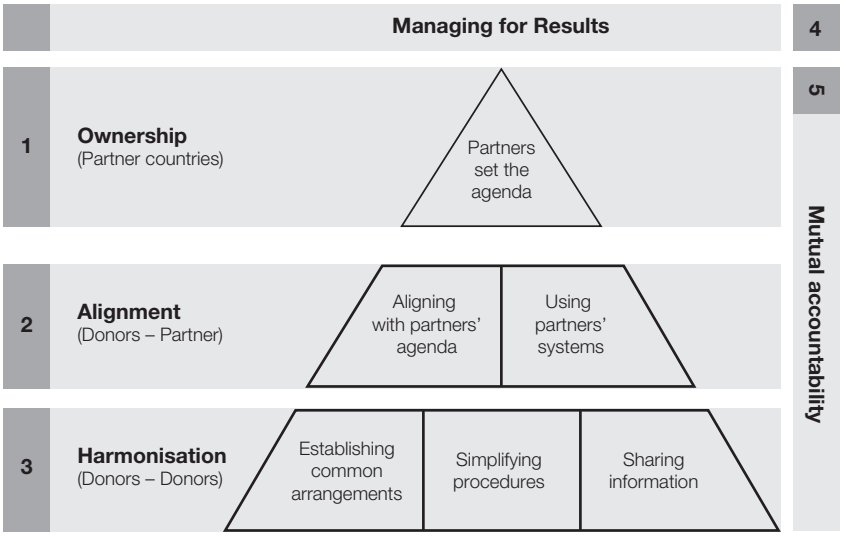
Within technical cooperation there has been some emphasis on moving from programmes that are purely vertical to programmes that include an understanding of the extent to which social determinants produce health, and of health systems' role in creating lasting change in health. However, this is not yet HiAP, which is a broad approach requiring many new capacities (see Chapter 14). Capacity building in HiAP is a crucial element in these aid modalities as the introduction of HiAP as a new approach has the potential to change established thinking and funding patterns. This issue is addressed further in section 13.5.

13.4 Changes in the global architecture of development assistance

Concerns about poor coordination of aid were voiced from the founding of the OECD in the early 1960s (1). During that decade, several papers examined issues that remain of concern in the twenty-first century, including: the volume of aid; lack of donor harmonization; need to untie aid; and a lack of policy coherence, including development assistance. Adoption of the MDGs led international actors to develop a renewed interest in addressing these long-standing concerns about development effectiveness (9). Consequently, global meetings (high-level forums) of development partners and LMICs have taken place triennially over the past decade. These meetings have resulted in several global agreements, including the Paris Declaration on Aid Effectiveness (2005), the Accra Agenda for Action (2008), and the Busan Partnership for Effective Development Co-operation (2011)(10). The Paris Declaration, in particular,

lays out key principles for aid effectiveness as well as indicators to assess progress (or its lack) towards realizing those principles in aid practice, as commitments to mutual accountability among LMICs and development partners. A monitoring framework with indicators was developed to support those commitments by measuring the progress of development partners and LMICs within the agreement. Together, the commitments to these principles and monitoring of progress were intended to catalyse a step change in development assistance, in terms of its coherence, effectiveness and sustainability.

Fig. 13.2 *Framework for the Paris Principles of Aid Effectiveness*



Source: Conway, Harmer & Spicer (11).

Several principles of aid effectiveness have emerged and developed in global discussions concerning aid effectiveness:

- country ownership of development assistance programming – this depends on better predictability of aid delivery for multiyear planning and budgeting;
- aid efforts and programmes in alignment with recipient country's national priorities;
- harmonization of aid design and delivery among development partners;
- results approach – using monitoring and evaluation to support evidence-based aid programming and to monitor aid effectiveness principles;
- mutual accountability and transparency between development partners and LMICs;

- civil society engagement – receives substantial rhetorical acknowledgement but has not risen to the level of other principles in development models, nonetheless this is necessary for development assistance to be appropriate, responsive and empowering for poor people (not shown in Fig. 13.2).

Two further points of evolution in development assistance followed articulation of the Paris Principles and their reaffirmation at the high-level meetings in Accra and Busan. In 2007, the International Health Partnership (IHP+) began a multiyear mandate to operationalize the Paris Principles in ongoing development assistance, focused on the health-related MDGs. Beginning with 26 signatories, including 7 LMICs, the IHP+ based its work on country compacts that codified agreed terms for contextualized application of the Paris Principles in each country. Importantly, the IHP+ signatories submitted themselves to an initial three rounds of annual monitoring, with indicators drawn or adapted from the Paris Declaration. By the third monitoring round there was evidence of some, albeit uneven, progress toward the commitments among IHP+ signatories (56, including 31 LMICs). Most importantly, LMIC ownership of development programming showed signs of improvement. A subsequent meeting of IHP+ country signatories in 2012 underlined that LMICs had made modest progress but development partners had shown little progress toward their commitments – echoing the OECD reports of the 1960s.

In 2008, the CSDH issued its final report with a series of recommendations for WHO Member States. This included (among other things) the adoption of a "comprehensive social determinants of health framework" for development assistance and "alignment of aid spending with the wider development plans of recipient countries" (6). Along with a focus on the need to incorporate social determinants into health policy and implementation, the CSDH highlighted several intractable and inadequately addressed problems within development assistance, including rising health inequities and insufficient engagement with civil society.

The key points related to the evolution and current state of development assistance relevant to a discussion on HiAP can be summarized as follows.

- There is widespread acknowledgement that development assistance for health does not cover the full range of determinants of health and that coordination with other sectors is required.
- Development assistance for health has a base of experience in intersectoral programming, particularly in education, agriculture, food and nutrition, water and sanitation, and livelihoods.

- The architecture of development assistance is in flux, with the advent of new types of actors, modalities of funding, governance agreements and principles for aid effectiveness.
- Change in development practice is occurring slowly; some aspects are being led by LMICs.

13.5 Potential for HiAP in development assistance for health

By taking health into account in public policies, HiAP has potential to improve policy coherence and aid effectiveness in the context of development assistance for health. As already discussed, some types of aid can be more conducive to intersectoral collaboration. Further, LMICs and development partners have had positive experiences relevant to HiAP even though the approach has not yet been used explicitly in the aid context. In order to facilitate its introduction into development assistance, capacity building in HiAP is important. This should include provision for creating an understanding of the importance of incorporating health perspectives among actors outside the health sector; negotiating HiAP among health specialists and non-health decision-makers; and training on tools for implementing HiAP, such as health impact assessments. LMICs and development partners will need to factor such capacity building into their development plans, programming, monitoring and reporting.

A fuller consideration of HiAP in the context of development assistance draws on Kingdon's multiple streams framework for policy development (12, 13). Under this framework, a successful approach to applying HiAP in development assistance will consider three non-linear streams that must coincide in order for policy change to occur. First, the problem stream consists of information that draws attention to the issue, based either on indicators and evidence or on public awareness of a crisis. Second, the policy stream involves technical specialists who can devise and propose alternative solutions. Third, the political stream catalyses the knowledge and proposals of the other two streams into policy change, based on the pressures and power dynamics faced by decision-making authorities (see Chapter 1 for a detailed discussion). Each of these streams is considered in turn.

13.5.1 Problem recognition: health is determined by factors outside the health sector

An understanding of limitations in current development assistance for health has already been established: for instance, vertical programming and programme silos are heavily criticized as neither sustainable nor effective pathways for

development within the health sector. In response to criticisms that its dominant funding position was actually undermining LMIC health systems, the United States President's Emergency Plan for AIDS Relief (PEPFAR) moved progressively from an exclusively HIV/AIDS-focused initiative to encompass broader sexual and reproductive health. PEPFAR's mandate now includes aspects of health systems strengthening (14). Similarly, the Global Fund has also included health systems within its scope for funding (15).

Going further, the OECD Development Assistance Committee (DAC) has affirmed that "health outcomes are influenced by many factors well beyond the health sector" and "[development] aid is the junior partner; the principal determinants of progress with health are domestic, including public policies" (16). For instance, the focus on schools as sites for hygiene and sanitation programmes to reduce water-borne illnesses (e.g. diarrhoea, dysentery) as well as faecal-oral transmission of pathogens (e.g. typhus) is increasingly common in developing country settings. Increases in female school enrolment and retention are well-accepted, proving a synergy in intersectoral action among the health, education and sanitation sectors. Similar intersectoral actions are also common among HIV/AIDS, nutrition and agriculture programmes; and in women's self-help groups and child health initiatives. The lessons from development assistance – the advantages of synergistic funding for health and reducing zero-sum antagonisms over scarce or restricted funding in the face of myriad health needs – apply to collaborative efforts across health and other sectors under a HiAP approach.

In summary, both development theory and practice for intersectoral action and a focus on social determinants provide a basis on which to improve population health more effectively and sustainably. This basis provides the knowledge, scope, awareness and openness to change required to apply the HiAP approach in the development assistance context.

13.5.2 Policy stream: need for intersectoral action on health

A successful approach to integrating HiAP into development assistance includes the following five characteristics (adapted from discussion of the Kingdon framework in Chapter 1).

1. *Technical feasibility*. As noted earlier, models of integration within the health sector and between health and other sectors are widely accepted in development assistance for health. Further, the focus on evidence and demonstration of results in aid programming provides a foundation for health impact assessments.
2. *Accepted policy values*. The development partner and the country recipient must agree on the HiAP approach. The Paris Principles and the IHP+

country compacts provide a common normative basis among development actors, above the specific commitments agreed to by LMIC governments and development partners. This shared set of values influences other actors in development assistance for health, including governments, agencies and civil society groups as seen in Figure 13.1.

3. *Cost effectiveness*. This has a theoretical basis in intersectoral action for health but the economic aspects of HiAP are yet to be demonstrated in a development assistance for health context. Such assessments should be a priority for pilot actions on HiAP in development assistance.
4. *Public agreement*. Civil society groups are among the strongest proponents of HiAP in development assistance for health programming. The challenges will lie with parliaments and publics, particularly in donor countries that have not recovered from the 2007–2008 financial crisis and have limited experience with HiAP in their home environments.
5. *Flexible approach to possible constraints*. This needs further work based on initial piloting of HiAP in development assistance programmes.

Development assistance for health has some institutional structures and principles of global governance. Hence, mainstreaming HiAP into development assistance will require identification of the ways in which it fits within the evolving structures and governance of aid and how HiAP can reinforce the purposes and goals of development assistance for health. The Millennium Villages Project (MVP) is an innovative example at the local (village) level (see Case study 13.1). There is a strong potential for HiAP at the national level in LMICs, where aid could better support the definition of national policy priorities that take health into account. The MVP and other cases provide positive examples of HiAP in the development context, thereby establishing a precedent for further integration of health into planning and programming in other sectors. The challenge is to scale up local initiatives so that they can be made sustainable and be gradually generalized nationwide.

13.5.3 Political stream: decision-making on HiAP among development actors

The political question about aid effectiveness does not concern new agreements but rather compliance with existing agreements, particularly the Paris Declaration, IHP+ country compacts and the subsequent pacts in Accra and Busan. As noted previously, the IHP+Results group has monitored improved behaviour among LMICs but poor actions toward international commitments among development partners. This suggests that the political issues faced by development partners may require the most attention. A key motivating lever

Case study 13.1 *A HiAP-type intervention in sub-Saharan Africa: the MVP*

The MVP is a current high-profile example of an intersectoral development intervention. With a microcosm of 12 local villages as units of intervention, the MVP provides a concurrent quasi-experimental series of HiAP-type interventions in a range of site-specific development contexts.

> The Millennium Villages Project is aimed at empowering and working with impoverished communities in rural Africa to achieve the Millennium Development Goals. The Millennium Villages Project (MVP) applies all the Millennium Development Goals (MDGs) – specific targets for reducing poverty by 2015, agreed upon by all countries of the world in 2000 – as a holistic package of site-specific interventions for 12 impoverished villages [in sub-Saharan Africa]. Millennium Village communities are … [intended as] a proof of concept that the MDGs can be achieved in a 10 year time frame at the local level, through participation and empowerment of the communities and investments and capacity building in different sectors (17).

The MVP package of interventions includes infrastructure and business development, agriculture, nutrition, education, energy, water, communications and environment, along with the health sector. These are all critical components that create a stronger analogy between the MVP and an application of HiAP in LMICs. The project explicitly aimed to address the MDGs in a holistic manner – again, similar to what would be expected under implementation of HiAP in a development context. At MVP sites, estimates of total MDG-related expenditures per capita per year were US$ 27 prior to the intervention, rising to US$ 116 as implementation took hold. Those estimates combine all sources of spending (MVP, government, local community and others).

Findings from the first of a series of evaluations demonstrated a range of health, economic and other outcomes for beneficiaries (see Appendix 13.1). The evaluators' conclusion articulated much of what would be expected in a HiAP intervention, based on the proof-of-concept approach of the MVP.

> Our analysis suggests that the integrated delivery of interventions across multiple sectors is feasible for a modest cost. … Although health sector interventions such as immunization and malaria control were potentially important drivers, **efforts outside the health sector** (agricultural inputs to improve food security and nutrition; interventions to reduce access barriers such as the elimination of user fees and the upgrading of roads, transport and communication; and basic improvements in water and sanitation) probably contributed to reported improvement in child survival (18) [emphasis added].

Case study 13.1 *contd*

With its intersectoral approach to international health and development, the MVP supports the relevance and applicability of HiAP in the context of development assistance in LMIC settings, in this case nine sub-Saharan countries partnered with a range of development partners.

for development partners is demonstration of results, but those results are usually at immediate output level. The absence of strong indicators and datasets for social determinants of health – as well as the need for multiyear timeframes to effect change together – may serve as distractions for development partners' decision-making. As noted in Chapter 5, donor countries' other priorities related to trade, intellectual property, market liberalization and protection of domestic interests (e.g. pharmaceutical industry, agriculture) may also hinder the introduction of HiAP on the development agenda.

In the prevailing neoliberal and globalized macroeconomic environment – and with the demonstrated deterioration of public health in the aftermath of the 2007–2008 financial crisis – there is a clear need to identify ways in which population health can be made more resilient to such external shocks. Several electorates have already demanded change in their health systems in the current crisis, notably in Europe with electoral defeats calling for discontinuation of neoliberal policies in 2009–2013 and the American public pressing for enactment of the 2010 Affordable Care Act. These post-2008 trends suggest an opportunity to advance the argument for HiAP among development partner actors, based on greater long-term efficiencies, capacity building for sustainable change and reduced dependency on aid. It remains to be seen how the balance between negative austerity measures that reduce development assistance and the counteracting political forces will develop.

In LMICs, the role of politics is exemplified in the experience of the Poverty Reduction Strategy Papers (PRSPs). These intersectoral actions were designed to guide comprehensive development across multiple social and economic sectors but, in practice, have sidelined health and other social sectors. This is largely due to the dominance of ministries of finance and planning in LMICs, with a strong neoliberal macroeconomic focus from the International Monetary Fund. This experience underlines the need for stronger planning capacity for ministries of health, other social sectors and civil society to negotiate productively with dominant policy-makers in LMICs. Also, for development partners to articulate a policy space for health linked to, and on a par with, economic development.

Conversely, there are political arguments supporting policy coherence for health. Development partners and LMICs share a common interest in the efficiency and sustainability of aid results, both of which are included among the five OECD evaluation criteria for development assistance (19). If it can be shown to enhance the effectiveness of existing aid efforts – and to promote long-lasting changes that reduce dependency on aid – then there is a political argument for introducing HiAP into development assistance.

13.6 Implementation of HiAP in the context of development assistance for health

In the broader development context, implementation of HiAP could take any of several forms, including the following.

- Capacity development for the health sector (including LMIC government and civil society) to promote skills in intersectoral dialogue and policy development in relation to health.
- Actions based on the CSDH final report recommendations, particularly to shift vertical programming and short-term bias among development partners towards an intersectoral approach to sustainable health improvements in aid programming.
- Piloting of HiAP in assistance, for example by testing elements of capacity building for HiAP among LMICs that show leadership in country ownership and other commitments under the Paris Declaration, such as those identified through the IHP+; or others that have introduced HiAP within their domestic policies.
- Formulation, testing and validation of new approaches for measuring changes in the social determinants of health (including indicators or other metrics) so that HiAP results can feed into the existing focus on results in development assistance.
- Brokering of intersectoral action on health (e.g. policy dialogues between decision-makers, including those from ministries of health, finance and planning and other line ministries) to leverage the value of development assistance across government in an environment of static or shrinking aid budgets.
- Complementarity in applying HiAP in development assistance. Adding elements of HiAP capacity building so that development partners and LMICs can gain experience with HiAP without necessarily reducing or changing existing commitments to vertical programmes or other aid modalities or undermining existing aid programmes.

Among development assistance tools, the emphasis on monitoring and evaluation and operations research is a useful base for introducing health impact assessments as part of a HiAP approach. The concept of intersectoral assessment has already been accepted in the development assistance context: for instance, the World Bank and others require environmental impact assessments for infrastructure and energy projects. The practice of incorporating assessments and evidence into decision-making has become a common feature in LMICs too. The South African Government's establishment of a Department of Performance Monitoring and Evaluation in the Presidency is a signal example.

13.7 Conclusion

There is widespread recognition of the problem of effecting lasting change in health. In conjunction with existing efforts to formulate solutions at policy and programme levels – and increased awareness of ways to accommodate divergent political interests that govern decision-making about aid – this growing appreciation represents a window of opportunity for LMICs and development partners to incorporate health into policy-making across all sectors. There are means of incorporating HiAP into the governance, principles and practice of development assistance. HiAP in the development context can be applied through steps by LMICs and development partners: ranging from piloting alongside existing aid programmes to a full approach centred on the social determinants of health.

Challenges in mainstreaming HiAP in development assistance are centred on the political stream, with the problem well-identified and alternative policy proposals available. Specific political issues revolve around the commitment to change among development partners, especially donors; and the dominance of the neoliberal economic perspective within finance ministries and development partners such as the International Monetary Fund and the World Bank. Those problems can be addressed through emphasis on HiAP's long-term effectiveness and its potential to reduce aid dependency. Also, through capacity building on negotiating skills of health specialists in government and civil society for intersectoral action and on measuring results of HiAP interventions. With that approach, HiAP has the potential to address the criticisms and shortcomings of development assistance and to improve aid effectiveness through more sustainable impacts on health inequities and in other development sectors. Without HiAP and other progressive approaches to health, aid will continue to be focused on the short-term and piecemeal without redressing the sources of health inequities and realizing health for all.

Appendix 13.1 *Three-year outcomes of the MVP 2009–2010*

The MVP evaluation was conducted in 2009–2010 in nine village cluster sites across sub-Saharan Africa. A three-year evaluation reported improvements in health impacts as well as outcome-level determinants of health and assessed changes in MDG indicators at each project site (18). Key findings that were statistically significant from baseline over the three-year observation period include the following.

Impact on mortality in children under 5 years (primary study variable):

- 22% decrease from baseline mortality in MVP villages;
- 32% decrease relative to matched comparison villages;
- 7.8% annual reduction in child mortality rates – three times faster than decrease observed in previous ten-year national data.

Impact on child morbidity:

- reduced malaria-related parasitaemia in children under 5 years (prevalence of *P. falciparum* decreased from 18.8% to 2.7%);
- 7.9% reduction in stunting rates among children under 2 years (implying better long-term nutritional status);
- reduction in diarrhoea prevalence, from 19.5% to 16.4%.

Health-related outcomes (three-year improvements):

- increased bednet utilization (for malaria prevention in children under 5 years), from 7.6% to 43.2%;
- increased antenatal HIV testing, from 28.8% to 70.1%;
- improved access to safe drinking water, from 12.7% to 77.4%;
- higher childhood measles vaccination rates, from 72.9% to 92.0%;
- greater coverage by skilled birth attendants, from 32.6% to 57.2%;
- increased postnatal check-up visits for neonates, from 6.9% to 14.3%;
- increased access to improved sanitation, from 1.9% to 28.6%.

Economic outcomes:

- reductions in household poverty – 47% increase in asset-based wealth scores;
- improved food security – 28.7% fewer households at risk;
- manifold increases in crop yields – by a factor of over 200%.

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Part III

Chapter 14

The health sector's role in HiAP

Kimmo Leppo, Viroj Tangcharoensathien

Key messages

- Health sector's own house must be in order if it is to gain credibility and the ability to communicate effectively with other sectors.
- Health sector should see itself as a social determinant of health and set equity priorities. Due attention should be given to creating a knowledge base; identifying and prioritizing issues; setting an agenda to ensure HiAP and adequate funding for implementation. Appropriate policy solutions and political decision-making should also focus on the implementation phase in which failures to achieve HiAP goals are most common.
- Manifold structures and mechanisms exist for preparing HiAP. Countries with different political-administrative systems apply different models but lessons can be learned from their experiences.
- Ministries of health often need to strengthen capacities for generating evidence, translating evidence into policy formulation, convening different sectors and stakeholders to reach consensus and actions on HiAP, and effective implementation. All these require different skills mix and capacity building. High turnover rates of staff make it challenging to sustain these capacities in developing countries.
- Improving population health and health equity normally takes much longer than most government tenures. Therefore, time frames and sustainability may pose particular difficulties for HiAP.

14.1 Governance of the health sector

In this context, health sector refers to organizations that are held politically and administratively accountable for the health of the population at various levels: international, national, regional and local. This chapter focuses on the national level at which health ministries, or similar bodies, play a major role in national health policy-making. One important message is that governance of the health sector has become even more complex and turbulent (1). Globalization and decentralization, the role of the media and various pressure groups (e.g. civil society organizations) have ever greater significance. Hence, in addition to its traditional functions of financing and/or service provision, it is well-understood that the health sector must work with other sectors and multiple actors in a more complex environment in order to improve health. This is the background for the development of HiAP.

The health sector should see itself as an important determinant of health and equity. Ministries' great responsibility for HiAP also lies in understanding the key roles of many other sectors (government and private) in influencing determinants of health. Policies and interventions in these non-health sectors may have positive and negative ramifications for population health. In turn, these sectors must be made aware that – despite a considerable contribution to the level and distribution (2–4) – the health sector cannot bear sole responsibility for population health, given the large portion of health determinants that lie outside its remit. Previous chapters argue this case convincingly.

With major responsibilities for health-sector governance, health ministries have many roles: identifying issues and providing an evidence base (problems stream); advocating for solutions; convening relevant parties, according to the issues at hand; taking the initiative; leading by example; and mediating and negotiating in order to arrive at policy design (policies stream). This entails navigating through territories that can be fairly straightforward but very often are complicated, time-consuming and conflict-ridden, in order to find a window of opportunity for political decisions (politics stream). In addition, health ministries need to ensure that decisions are implemented and monitored from the health and equity perspective and take immediate corrective actions where appropriate.

In order to work effectively with other sectors, the health sector's own house should be in order. The higher the social and political credibility of the health ministry, the stronger its position in convincing others and the greater the possibility of successful HiAP. Acting as a social determinant of health, a health ministry must: (i) ensure that health programmes and systems (including health protection and various levels of care) are designed and delivered to reduce rather

than widen health inequity; (ii) keep track of the activities of other sectors that have a bearing on health; (iii) understand and respect the legitimate interests of other sectors, their strengths and limitations, and apply effective approaches in dealing with them; and (iv) make use of the vast scientific and professional expertise at hand: opinion leaders within the medical and nursing professions, public health associations and similar bodies.

Whether explicitly or implicitly, policies always contain two elements: evidence of some kind and some set of values. Also, power relations are involved. It is important that the health sector formulates health policy on both a solid evidence platform and a value base which is explicitly anchored on equity. Social equity in itself is conducive to health (5, 6). Public policy interventions (including health) often benefit mostly the best educated and well-to-do sections of the population as they have better means to access services than those who are poor or less educated. Therefore, positive discrimination measures that give higher priority to under-privileged and vulnerable people should be an essential part of any policy to actively minimize equity gaps (see Chapter 4).

14.2 Setting priorities for policy design

Priority setting for HiAP has no hard and fast rules but several considerations are useful under different circumstances. Selectivity is key as it is not realistic to proceed on too many fronts at the same time. Approaches should be applied step-wise or issues sequenced in terms of their public health importance, amenability and consideration of context specificity and both technical and political feasibility. Potential areas for action should be chosen by applying criteria such as:

- problem or issue is of major public health importance;
- problem or issue is amenable to change and change is feasible (i.e. there is sound evidence about how it can be tackled);
- potential solutions are politically and culturally acceptable.

Sizeable results can be obtained most often in fields that have common interests across sectors. Long-term experiences with this approach have been documented in cases from Finland, for example (7, 8). Traffic safety to diminish accidents and injuries is a typical example: achieving quick results without massive resources in several LMICs. The educational and health sectors share similar value bases and a common interest in equity. In circumstances of very high mortality among mothers and in children under 5 years, it goes without saying that all concerned sectors and political domains prioritize joint endeavours to promote maternal and child health; food and nutrition security; and education.

The examples cited can be called consensual fields of action (see Chapters 3, 6 and 9).

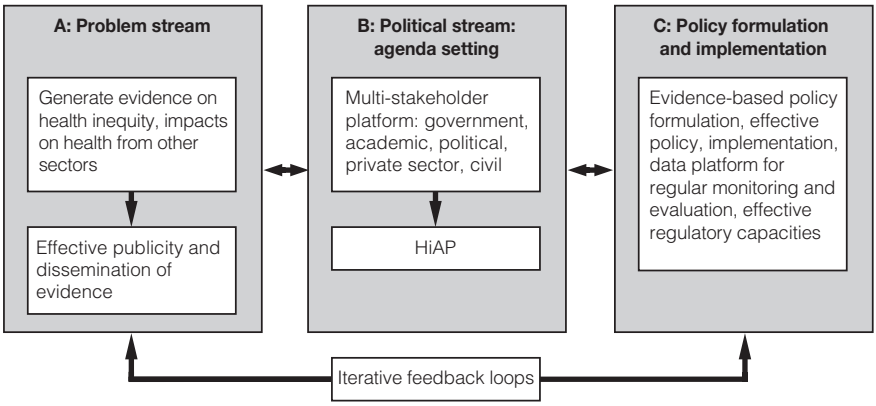
Most importantly, opportunities to instil HiAP initiatives into the political agenda must be seized when the time is right. Windows of opportunity open most often in connection with general elections when prospective policies are announced in party manifestos or blueprints for key strategies. In many countries medium-term socioeconomic plans or strategies are designed at regular intervals where multisectoral actions can be initiated. The latter are perhaps the most powerful decision-making processes because national planning agencies and ministries of finance are the key drivers.

Sometimes, all stakeholders are brought together by a major health hazard or crisis, such as bird and swine flu and severe acute respiratory syndrome (SARS). If well-managed, such dramatic situations may greatly improve multisectoral trust and capabilities. Given the urgency of a catastrophe, it is important that the health sector has reasonable policy solutions to offer as this will build trust and credibility.

14.3 Managing the policy process

Fig. 14.1 depicts three aspects of policy processes: (i) the problem stream; (ii) the political stream; and (iii) policy formulation, together with the iterative loops of evidence generated from monitoring and evaluation in order to fine-tune policies. Ensuring HiAP requires skills in all these aspects of policy processes. It should be noted that the interplay of interests among policy actors – having different power and influence – shapes policy contents in a complex manner.

Fig. 14.1 *Policy processes*



To fulfil these responsibilities in ensuring effective HiAP, the health sector should build up and strengthen institutional capacities and develop the following skills in line with the three aspects of policy processes.

14.3.1 Problem stream

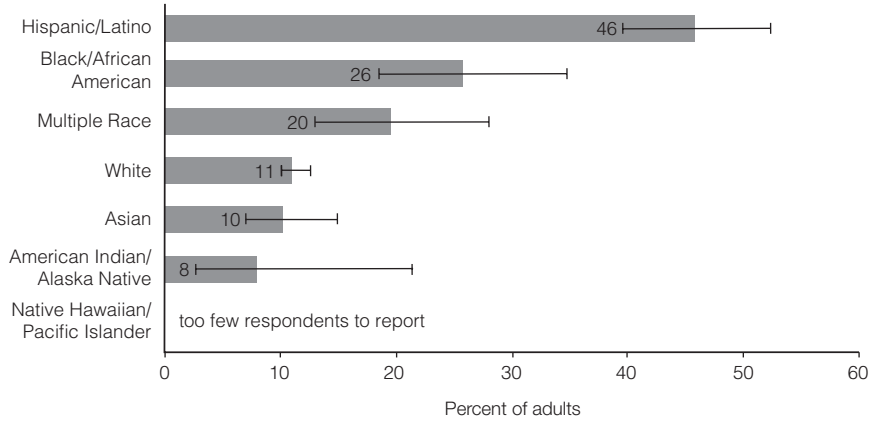
It is important that health ministries strengthen capacity to generate evidence on the degree to which their own and other sectors' policies impact on health and health equity. Generation of evidence may require development or application of different tools such as health impact assessment, environmental impact assessment and health equity impact assessment. ADePT, a tool developed by the World Bank, is useful in producing health equity and financial risk protection across population group differentials (e.g. rich–poor, urban–rural) by analysing micro-level data from various types of surveys (e.g. household budget; demographic and health; labour force) in a systematic and comparable way (9). These skills can be strengthened by training but high turnovers of well-trained staff in developing country health ministries makes it challenging to sustain such capacities. One successful example resulted from an agreement between the Thai Ministry of Public Health and the National Statistical Office (NSO): it is now routine practice for all national household health and health-related surveys conducted regularly by the NSO to include a module on household ownership of durables and housing characteristics. This enables creation of a wealth index for regular health equity monitoring (10).

In addition, effective publicizing and dissemination of evidence are essential for bringing together all stakeholders and gradually forming public opinion. This requires use of media appropriate to different audiences: for example, the general public, parliamentarians and civil society. In some countries, well-trained and informed health journalists are critical for transmitting evidence on health inequity to the general public. It is customary for politicians to scan the front pages of newspapers and to be responsive to public concerns. The media should take such opportunities to voice health inequity, raise public concern and catch political responses.

Strong evidence tends to indicate that regular reporting is the only means of exercising soft power, and a powerful instrument. For example, the annual report on progress in implementing the International Code of Marketing of Breast Milk Substitutes details compliance with, and violation of, the Code at national and global levels. This has attracted much policy attention, leading many countries to incorporate the Code in national legislation (11): transforming it from a soft instrument (code of practice) to hard law and enforcement. Generating evidence on health inequity, and health impacts from other sectors' policies is the key entry point and an essential skill for a ministry of health. King County

in Seattle offers a good example of a local initiative working for social justice and equity. An annual report (12) depicts the problem stream and intersectoral actions and is made publicly available. This acts as a tool for exercising soft power by holding all sectors accountable for health, social justice and equity in society (see Fig. 14.2).

Fig. 14.2 *Percentage of uninsured adults (18–64 years) by race and ethnicity, King County, three year average 2008–2010*



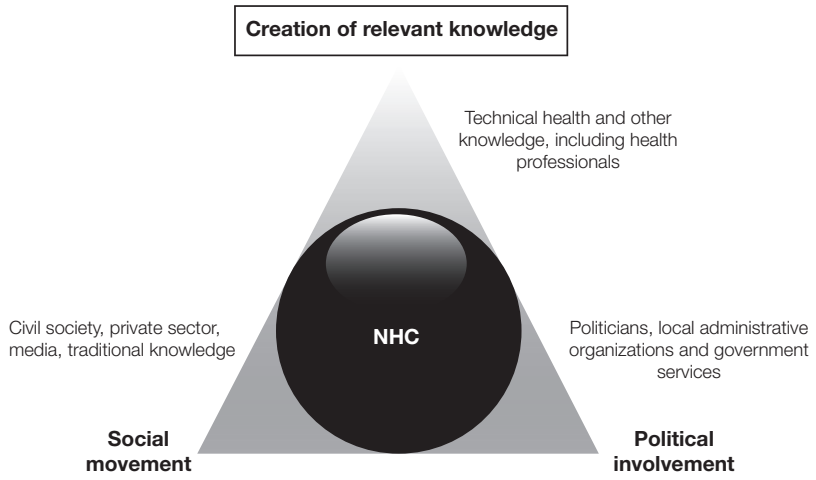
Source: King County, 2012 (12).

14.3.2 Political stream

Three synergistic powers move the political agenda: (i) the power of knowledge and evidence; (ii) the social power of civil society; and (iii) state power through accountable political leadership. These three powers must act in combination to overcome large, usually immovable, difficulties. This has been called the "triangle that moves the mountain" strategy (13). Such strategies have been applied successfully in formulating healthy public policy through a multisectoral body (14) (Fig. 14.3). For example, the Resolution on Control of Marketing Strategy for Infant and Young Child Nutrition was adopted at the Third National Health Assembly in Thailand in 2010 (15). This resulted from continuous dialogues between multiple partners including government ministries (e.g. health, labour, finance, social welfare) academia, civil society, media representatives and UNICEF.

To apply Kingdon's concepts, this is a situation where a window of opportunity may or may not open, depending on the political climate or public mood, political power relations and other factors. There may be long time lags (e.g. needing a change of government/minister) but sometimes these windows occur very suddenly, even by chance. High-level officials must be prepared to seize opportunities and act swiftly in 'marketing' good and well-thought-out proposals to politicians.

Fig. 14.3 *Combined force of knowledge power, social power and state power*



"The mountain means a big and very difficult problem, usually immovable. Combination of the 3 elements in the triangle is essential to overcome any difficulties." (*Prawase Wasi*) Thai health reform has been strongly influenced by this concept. In the National Health Assembly, the National Health Commission (NHC) acts as a coordinator, aiming to bring together the three elements of the triangle to achieve change.

Source: Wasi P, 2000 (13).

14.3.3 Policy-making mechanisms to move health higher on the political agenda

A ministry of health should be skilful in exercising convening power, inviting all relevant sectors and stakeholders to engage in open talks and reflection on the health implications of their respective policies and steering towards consensus on the solution streams. Dealings with non-health sectors may be limited by the health ministry's weak status and scarce resources, particularly in low-income countries. This can mean that there is inadequate convening power for cross-sector meetings and seeking solutions. Even well-equipped health ministries should conduct such difficult discussions respectfully and diplomatically in order to avoid any impression of health imperialism. At times, the head of state or his/her designates (e.g. deputy prime minister, minister responsible for intersectoral actions), or national planning bodies have the most convening power and authority to reach consensus on solutions leading to legislation and law enforcement (see also Chapter 6).

Many different structures and mechanisms are available to accomplish intersectoral governance and cooperation (16). Whether temporary or more permanent, having a wider or more focused participation, structures must be tailor-made and context specific to suit the policy environment and culture of

the particular country. A common feature is to bring together all concerned parties and key stakeholders, most often through interdepartmental committees within government structures. It is desirable that such bodies are in proximity to the executive power in the country, having access to the highest political level of decision-making. Such arrangements are also conducive to joint planning, budgeting (when needed) and implementation, and provide an enabling forum for designing legislative instruments (Case study 14.1).

Case study 14.1 *A multisectoral national HIV/AIDS policy in Namibia*

Norbert Foster

In many systems, the national level is key in providing the support and enabling environment required for cooperation at intermediate and operational levels. A good example of a focused HiAP in the form of an 'HIV/AIDS in all policies approach' may be seen in Namibia, where the Ministry of Health carries overall responsibility for coordinating and leading the national multisectoral HIV/AIDS response.

Namibia's National Policy on HIV/AIDS of 2007 was based on an extensive evaluation and review of HIV/AIDS initiatives implemented in all the priority sectors (including health, education, child and social welfare, information, agriculture, infrastructure and transport, tourism, public services). The results of the evaluation were well-documented, widely distributed and subsequently utilized to inform a broad multisectoral process of policy formulation. This process was designed to incorporate capacity building among key technical staff of all sectors in specialized areas including data analysis, stakeholder interviewing, policy formulation and monitoring and evaluation. Compilation of a clear monitoring and evaluation framework was implemented in parallel. This focuses on the key indicators to be reported on and specifies the responsible sector and frequency of reporting.

The broadest possible national consensus on, and co-ownership of, the policy was generated by engaging sectoral leadership through specific sectoral consultations, before cabinet approval and parliamentary endorsement was obtained.

Implementation of this policy was enhanced by the formulation of a national strategic implementation plan, annual joint reporting and review sessions, and regular supportive supervisory visits to operational level by a multisectoral team. These visits enabled direct and rapid feedback on implementation problems experienced in the field. Cross-cutting – as well as particular capacity challenges related to staffing, skills, logistics and other

Case study 14.1 *contd*
resources – was addressed through coordinated interventions from the Ministry of Health at national level, with technical and financial support from key development partners.

Public hearings, commissioner reports and other parliamentary processes are commonly used in several countries. Generally, all relevant multiple stakeholders (particularly representatives from the general public and prominent citizens) are involved in these participatory processes where civil society organizations are vital in achieving a balance with private sector interests and protecting the interests of the public. A number of case studies in previous chapters reiterate the importance of this approach, which in some cases is a constitutional requirement.

In many circumstances it is appropriate for the government to provide public health reports to parliament, especially in countries where such mechanisms are used in fields outside the health sector. These are quick and relatively easy approaches which become a statement of the whole government. In addition, the resulting feedback from the parliament is useful for further policy development or legislative processes. One effective way to ensure whole government involvement requires policy documents from multisectoral committees or task forces to be submitted for government approval in the form of a decision in principle. In countries where such a political procedure is commonly used, this is a powerful support tool for implementation and further work.

Many, if not most, countries have an obligatory requirement for all government bills submitted to parliament to include an estimate of the economic and financial implications of the proposal. More recently, assessments of environmental effects have also been required, where applicable. Section 67 of the Constitution of the Kingdom of Thailand B.E. 2550 (2007) includes a mandatory requirement for environmental and health impact assessment for any project or activities which may have serious effects on the quality of the environment, natural resources and biological diversity (17). The EU is also adopting a requirement to assess social, health and equity implications of major investments within various policies (18, 19).

14.3.4 Implementation issues

In research on policy processes, there is a common finding that implementation is the phase in which difficulties and failures very often occur due to complex issues (20, 21). A number of reasons explain failures in effective implementation of HiAP. For example, all energy may have been spent on policy formulation;

practical constraints or obstacles may not have been anticipated; and responsibilities of parties and relationships between lead agencies (often those other than health, such as traffic or water) and others may not have been clarified. Stakeholders who have not been closely involved in preparations may lack commitment; this is most likely the reason for an implementation gap in major previous international health policies (primary health care, Health for All). Further, resource needs may not have been worked out sufficiently to convince the health or finance ministries.

These problems have been aptly paraphrased by the question "policy papers – papers or policies?" (22). Just as the proof of the pudding is in the eating, the proof of a policy is its effective implementation. Effective regulatory capacity and law enforcement is needed at the implementation of HiAP. Regulatory captures are common in settings with poor governance: regulatory agencies are eventually dominated by those they are supposed to regulate so that the regulator acts in ways that benefit the regulated partners and fails to protect the public interest. There is much room for improvement of regulatory capacities in developing countries (23), as described in a few key pieces of literature (24, 25).

14.4 Current weaknesses

Often ministries of health or similar policy-making bodies are not well-equipped to carry out these roles. In many low-income countries, health ministries are weak and health is seen as a consumption sector rather than one that enhances human capital and generates national wealth. Too often, health sectors are highly compartmentalized, based either on levels of medical care (e.g. primary health, hospitals) or disease-oriented (communicable, noncommunicable or HIV/AIDS, TB and malaria) structures; and health ministry policy-makers are overwhelmed by day-to-day crisis management. Expertise is often too narrow, comprising the medical and nursing staff, lawyers, finance professionals and statisticians necessary for administration of health. The HiAP approach requires a wider professional mix: people with broad understanding and knowledge of modern public health and staff trained in economics and policy sciences.

High turnover of staff is challenging as well-trained health professionals are either promoted and move up the hierarchy or quit the ministry due to low incentives, poor motivation, low morale, bureaucratic inertia and lack of social recognition. The long-term sustainability of institutional capacities is at risk.

14.5 Improving capacities and performance

When the required expertise does not exist, it should be built gradually through systematic development of capacity. But this is more than training of individuals, it has an institutional dimension: creating teams with a broad knowledge and skills mix. This takes a medium-term investment as short cuts are seldom available.

Self-initiative, local ownership, external support from international partners, equitable sharing of benefits (financial and non-financial), critical mass of committed researchers, policy-relevant research, political impartiality, programmatic and financial accountability and a collegial environment are among the key success factors for sustaining capacities (26).

14.5.1 Practical examples of capacity building

Evidence gathering for informed policy decisions can often be carried out by research institutes at arms length of the ministry of health or by academic bodies specializing in policy research. It is important to maintain scientific independence: not too close to be dominated by the ministry; not too distant to be policy irrelevant. The strengths and weaknesses of a number of such think tank institutions, including academic arms-length institutions, have been fully described and assessed (27, 28).

Normal scientific inquiry looks at causal relationships or causes and effects and has a different logic, language and thinking. Policy-relevant research looks at goals and solutions for social problems, although organization of this capacity varies considerably across countries. It is also useful to separate two functions: (i) generating policy-relevant evidence; and (ii) addressing political aspects of policy-making, covering value-based judgments, interests and handling of the power relations typical of politics. The former is a typical function of the type of institutions described here whereas the latter belongs more to the political level, particularly ministries and government.

Health ministries in developing countries seldom have sufficient capacity for analytical and evidence-gathering purposes. However, they play a vital role when policies are brought to the political forums. With support and involvement from the community and civil society (who should be brought to the process early), the health ministry's role is to lead negotiations with other relevant ministries or to take matters to the government. The latter happens most often when new legislation is adopted or budget implications of policy implementation are assessed.

Box 14.1 *Institutional capacity development*

Pekka Puska

Increasingly, countries are developing their national public health institutes in order to build institutional capacity under the ministry of health. Such institutes serve the political ministry by providing relevant public health information and permanent expertise and by helping to implement and coordinate ministry of health policies and programmes. The International Association of National Public Health Institutes currently has some 80 member institutes from all continents.

In spite of great intercountry variation due to historical, cultural and economic factors, institutional capacity development has been somewhat similar in many countries. Public health institutes or laboratories have gradually been developed from infectious disease laboratories to include broader areas of public health and, increasingly, to add national public health expertise issues to core national routine functions. Thus, national public health institutes help the ministry of health to implement core public health functions, implementation of national health monitoring being one of the most important. Through contact with institutes and stakeholders in other relevant sectors they also help implementation of HiAP.

14.5.2 Handling controversies and dealing with conflicts

Reaching stakeholder consensus on goals is straightforward. However, policy interventions are complex and therefore controversies and conflicts of interest often arise across sectors and between actors. It is not difficult to agree on goals in general terms but difficulties arise in reaching consensus on policy options and instruments for solutions. Essentially, this concerns how to effectively minimize the 'knowing-doing' gaps by means of a political process; broad-based engagement towards shared goals; and acceptable, feasible policy instruments (see examples of country experiences in Chapter 4).

Nevertheless, there are many areas of conflict or controversial issues, most often between health and commercial or trade interests (see Chapters 5, 10 and 11 for typical examples). At least three considerations should be borne in mind: (i) brokering and negotiation may not result in ideal solutions but it is important to open the way for step-wise progress as incremental change is better than no change at all; (ii) compromises that are known to dilute an issue should not be accepted since they slow the desired change (e.g. voluntary code of practices with tobacco or alcohol industries); (iii) confrontation is a tactic that rarely works. Sometimes, very effective public information and persuasion may produce sufficient demand among the general public and this can become a political force to drive change without serious confrontation and deadlocks.

It must be admitted that some obstacles to health-oriented multisectoral policies currently appear insurmountable in many countries (see particularly Chapter 11 on alcohol). In such cases the best strategy may be to minimize the harm done: damage limitation.

14.6 Special problems in HiAP: time frames and sustainability

Time lags in HiAP present a serious problem, whether in policy design between various actors; decision-making; anticipation and execution of the implementation process; or monitoring of results. Government and other stakeholders often require quick and visible results in terms of health outcomes, therefore realistic time frames should be established in advance. Time lags can be prolonged and sometimes can be partially overcome by visible initial steps such as budgetary allocations or, even better, process indicators such as changes in attitudes or behaviour.

One important positive point should be noted here. Evidence from general social science and public health literature (e.g. on demographic and epidemiological transitions) shows that diffusion of innovations is often faster among latecomers. They can benefit from all the lessons learnt by the forerunners.

Perhaps the most relevant aspect for HiAP is the importance of commitment and continuity extending over a number of successive periods of government. Policy continuity is indispensable for sustained implementation which usually is the most demanding part of the policy process. It is also essential for steering the process; ensuring that resources are adequate for implementation; effective monitoring of progress for mid-course corrections; and amending policies in the light of experience gained.

14.7 Conclusion

Ministries of health play active roles amidst complex determinants of population health that lie outside the health sector. Through convening power and consensus building they should be able to handle conflicts and controversies across different government sectors and other stakeholders. Also, to engage and mobilize society as a whole, including civil society and community groups, in pursuit of shared societal goals for HiAP. In order to achieve such ambitious goals, the health sector has to build and strengthen its capacities for generating evidence and for effective working relations with other sectors.

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Chapter 15

Lessons for policy-makers

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Key messages

- HiAP is based on the fundamental values of human rights and equity.
- Problems come to political agendas due to acute situations or crises as well as persistent and sustained efforts at national and international levels.
- Identification and prioritization of the need for HIAP and feasible policy solutions can be triggered by processes to: (i) address health and health equity problems requiring intersectoral solutions; (ii) achieve high-priority government goals with synergies to health; and (iii) examine policy proposals arising across government sectors with health impacts.
- Political will and the power of knowledge, civil society and the state are crucial political forces for moving health issues onto policy agendas.
- Arguments on the intrinsic value of health or health's contribution to sectoral or societal gains can be useful in discussions with politicians and policy-makers across sectors. Corporate interests can be powerful in permeating the policy dialogue and could undermine government actions.
- Policy-makers need to be prepared and quick if they are to seize opportunities when they arise. A sense of strategy and timing are essential.
- Key determinants for successful implementation include early involvement of relevant actors; a high level of political and public support; technical, administrative and managerial capacities across government sectors; complementary interventions; legal backing; and monitoring and evaluation systems.

- HiAP finds support in the human rights and obligations developed under international law and implemented in national laws and policies.
- HiAP is feasible in countries of any stage of development.

15.1 Introduction

This book is based in the fundamental values and principles of human rights and equity emanating from the United Nations Charter and declarations and the WHO Constitution. These are common values to which all Member States have pledged to adhere and there are many other similar commitments at supranational, international and national levels. However, this wide agreement on principles and values has not translated into systematic and comprehensive adoption and implementation of policies conducive to population health and equity. In fact, the vast differences in health between and within countries demonstrate that the values and principles have not yet materialized for many people in the world. People still die prematurely, suffer from preventable diseases and are deprived of developing their full potential, due to ill-health. This book has therefore discussed the challenges of incorporating concerns of health, health equity and health systems (hereinafter abbreviated to 'health') into all policies across government sectors.

The values and principles guiding this book are not only high-level political commitments. This book has also brought to light that they play a major role in any concrete process trying to put health on the political agenda or seizing the opportunity for adopting and implementing HiAP. Almost every chapter raises the importance of the value base. Often, these become apparent and concrete when they conflict with values exposed by industry, trade or commercial interests that tend to neglect or undermine the values of universalism and equity. It is hoped that this book will inform the debate and encourage policy-makers to pursue practical ways of translating the values into better population health.

To accommodate the perspectives of policy-makers, this book takes as a key starting point the recognition that policy-making is a dynamic and, usually, non-linear process. Common assumptions hold that there is a stepwise progression from analysis, through decision-making to implementation. In fact the reality is messier, affected by diverse political and social contexts; the interplay of various actors with differing values, interests, capacities, power and resources; and the need to respond to opportunities and obstacles as they arise. The dynamic and at times unpredictable nature of policy-making poses challenges for integrating HiAP.

This chapter is framed around a set of questions raised in the first chapter (see Box 15.1), addressing them with the aim of providing valuable lessons on seizing opportunities arising from the interplay of problems, policies and politics and the implementation of policies, identifying their implications for integrating HiAP. This concluding chapter brings together some of the evidence and key findings presented in previous chapters and draws out some lessons that it is hoped will be of value for policy-makers.

Box 15.1 *Key challenges for applying HiAP*

- How do health issues get lifted on political agendas?
- How are health problems and intersectoral solutions identified and prioritized?
- What motivates or incentivizes politicians and policy-makers across sectors to take into account the consequences of their policies for health?
- How can windows of opportunity for improving health and health equity be seized?
- What are the key determinants for successful policy-making and implementation of HiAP?
- What is the role of the health sector in policy-making and implementation for HiAP? What capacities are needed within the health sector to advocate, negotiate and implement HiAP?

15.2 Lessons for policy-makers

15.2.1 Lifting health issues onto political agendas

This book identifies a number of ways in which health issues have come onto national or global political agendas, and ultimately affected policy decisions. Acute situations or crises ('focusing events' in Kingdon's terminology) posing an immediate health threat are most likely to thrust an issue into the national political consciousness. This creates public or other pressures for governments as a whole to respond – and thus often facilitating intersectoral actions. Powerful examples relate to food safety, environmental disasters or the threat of pandemics. The catastrophic health consequences of bootleg liquor in Ecuador (Chapter 1), a sharp rise in alcohol poisonings in Zambia (Chapter 11), or the offloading of toxic waste in Côte D'Ivoire (Chapter 12) are good examples of how focusing events can be powerful factors in gaining political attention and thus raising an issue on political agendas.

Other crises may be slower to emerge but, once they become politicized, space may open up for responses that incorporate health into other sectors' policies.

Such is the case for the multifaceted problem of homicides in Brazil (Chapter 11). Instead of promoting alcohol consumption as a public health problem, the visible consequence of alcohol consumption (homicide) provided a successful entry point for incorporating health interventions within a broader policy agenda: for areas such as crime and urban planning.

Often several decades of persistent and sustained efforts, at both national and international levels, have been necessary to persuade politicians and policy-makers to address an issue. At the *national* level, issues are being raised on political agendas by longer-term processes. For example, through the emergence of public health issues directly associated with the actions of other sectors (particularly notable in the environmental field) or through the creation of a growing body of scientific evidence that demonstrates the importance of actions on health and equity across sectors. This book provides several examples of sustained efforts, including Sweden's firm commitment to universal social policies in early child development (Chapter 6); systematic efforts in India to develop evidence, provide feedback to policy-makers and promote policy change in malnutrition (Chapter 9); or Brazil's persistent endeavours to tackle high levels of tobacco consumption (Chapter 10).

The majority of chapters refer also to the role of *international* efforts, particularly in bringing critical health issues to global and national attention. Such efforts have included systematic accumulation of scientific evidence and indicators to assess the magnitude of a problem and provide feedback to policy-makers on key trends in population health. For example, the Global Burden of Disease Study (a WHO initiative) was highly instrumental in challenging the misperception that mental health was not a major issue in low- and middle-income countries (Chapter 8). Initiatives such as the WHO CSDH (Chapter 4) or the ILO's Decent Work Agenda (Chapter 7) have been notable for translating a large, varied and complex body of evidence into simple, understandable key policies and thus facilitating its uptake by policy champions and policy-makers across sectors at the national level. Another key element of success has been visible support at the highest level of international agencies in the form of international expert committees and high-level political declarations (Chapters 10 and 1). National and international processes are intimately connected: national action can produce evidence of success and catalyse international action; international action can promote uptake at national level, as in the case of the initiatives on social determinants described in Chapter 4.

15.2.2 Identifying and prioritizing a need for HiAP and feasible policy solutions

Drawing on the evidence from this book, it is possible to identify three types of processes that can require prioritization of a need for HiAP and feasible policy solutions. Realistically, not all problems can be tackled so they need to be prioritized together with politically, financially and ethically feasible policy solutions that would necessitate action across sectors.

Firstly, a process that starts with a *problem in health, equity or health systems requiring intersectoral policy solutions*. All chapters in Part II show the importance of long-term research exploring the problem, its causes and, in particular, developing evidence on intersectoral solutions and their technical feasibility, potential costs and benefits for health and for society as a whole.

Secondly, a process arising from *a high-priority government goal* that would benefit from a whole-of-government approach and has synergies with health. The cases of early childhood development in Chile (Chapter 6); occupational health in China (Chapter 7); nutrition in India and Malawi (Chapter 9); or prolonging working lives in Finland (Chapter 8) are examples of multifaceted problems given high-level political priority and needing effort across sectors (as discussed in Chapter 2, this is also called the whole-of-government approach). Thus, the health sector can not only facilitate the achievement of government goals but is also provided with important opportunities to advance its own agenda. This situation can also provide support to broader policy solutions, such as sector reforms or redistributive policies.

Thirdly, a process that starts from a *policy proposal emanating from government sectors* or international actors, with potentially important impacts on health. Examples noted in this book include timely engagements in negotiations on international agreements that may affect (for example) marketing, labelling and trade in harmful products, or regulation and trade in health services, so as to avoid negative health consequences (Chapter 5). Also, the rich experience from the environmental field that includes routine use of impact assessments as institutional intersectoral procedures (Chapter 12). Engagement in important national or international processes that might result in binding norms, standards, agreements or financial allocations – such as those in the field of sustainable development – is crucial to ensure that health is properly included on the agenda (Chapter 12). Familiarity with institutional processes and priorities of other actors, in both government and at other levels of governance, is fundamental to the ability to contribute in a timely manner. It is also necessary to identify the appropriate level of engagement (regional, national, global) as well as the appropriate time for the input that would yield most results. For

example, Chapter 8 on mental health promotion proposes that mental health should be incorporated in the strategic planning of ministries responsible for education, social welfare, police, courts, prisons, probation services and child protection.

Identification of possible actions and policy instruments is normally the task of the policy community of researchers, civil servants and civil society advocates with the mandate and expertise on a given problem, yielding a range of policy options for improved health and health equity. However, choice of a feasible solution will be determined by the timing, sequence and political context at any moment. Sometimes only 'soft' measures are available to engage other sectors, such as sharing information or entering a policy dialogue in order to introduce a health perspective. Sometimes, legal or regulatory measures are necessary. A stronger instrument may be the use of budgetary allocations, for instance to strengthen national capacity and institution building for intersectoral work (see Chapter 14). Cross-sectoral initiatives can include health-related taxes, as noted in Chapters 10 and 11 with reference to tobacco and alcohol.

A few lessons emerge from the perspective of the health sector wishing to bring health issues to the attention of other sectors. First, the health sector must establish itself as a credible partner, with analysis of problems and solutions based on strong evidence and technical expertise. Second, the health sector must be clear on the feasibility of policy solutions in a given political and socioeconomic context and their acceptability to other sectors. A solid evidence-base and identification of the most cost-effective interventions can be helpful in cases when ideology or vested interests intrude (Chapter 11).

All in all, it is clear that the conditions for setting priorities for HiAP and the choice of policy solutions emerge in a given political-economic circumstance, with opportunities arising from sectoral or high governmental priorities. The degree of priority would be relative to the magnitude of the problem, the feasibility of a meaningful engagement and the possible consequences on health, equity and the context of health systems.

15.2.3 Motivating and incentivizing policy actors to take health into account: the politics of HiAP

A crucial part of any approach to HiAP involves motivating or incentivizing policy actors to take health into account in public policies across sectors. Throughout this book it is stressed that the existence of political will is an important precondition for moving health issues onto political agendas. Policy entrepreneurs such as dedicated civil servants, researchers, civil society advocates and politicians may themselves be champions for policy change:

persuading relevant actors, translating knowledge and evidence, generating media attention, negotiating political trades and brokering conflicts as they arise. Chapter 14 makes reference to the combination of power of knowledge and evidence, social power of civil society and state power through political leadership as the "triangle that moves the mountain".

This book also identifies supporting mechanisms that can incentivize policy actors to take action. This includes the establishment of cross-sectoral alliances or partnerships, which can be useful instances of networking and consensus building. Examples include Thailand's NHA (Chapter 5); the SUN movement (Chapter 9); the ILO and WHO joint effort to develop a BOHS approach (Chapter 7); or the Framework Convention Alliance (Chapter 10). All have played an important role in generating political action.

Incentivizing government sectors requires the development of trust and building consensus on goals and policies across sectors as facilitators for success. It is equally crucial to understand the goals, languages and processes of other government sectors, as the incentives for action are often linked to particular policy processes and priorities at a given time (Chapters 8, 9 and 10).

The volume identifies at least three types of arguments that can be persuasive in encouraging policy actors to take health into account in public policies.

1. *Health argument*. Health has intrinsic value. A powerful argument for policy-makers to act can arise from understanding of the health impacts deriving from a particular risk factor (e.g. tobacco or alcohol consumption, occupational health hazards) or determinant of health (e.g. social as in Chapter 4**,** environmental as in Chapter 12). Failure to comply with obligations arising from ratified international laws or constitutional rights can also be used to build this argument. For example, all WHO Member States acknowledge that governments are responsible for the health of their populations and 193 countries have ratified the CRC (Chapter 6).
2. *Health-to-other-sectors argument*. Improved health and equity can support realization of mandates and goals of other government sectors. The book shows the importance of early childhood development as a key determinant of children's learning capacities (Chapter 6); also, the impact of good health on work ability (Chapter 7). The case of Zhejiang Province (Chapter 8) presents a concrete example of the synergies arising from healthy nutrition, a positive atmosphere, increased physical activity and children's and adolescents' ability to learn. The evidence shows that such complementary interventions are also prerequisites for successful implementation (see below).

3. *Health-to-societal-goal argument*. Improved health and equity can also contribute to wider societal gain, including well-being, economic and social development and financial and environmental sustainability. The case study from Finland shows how the health, education, trade and employment sectors aligned actions towards a strong government goal of prolonging work life (Chapter 8). A similar notion can be found in the framework for sustainable development in Chapter 12.

Economic evidence can be highly supportive for all three arguments: for example, assessing the financial benefits for health and social care, productivity gain or increased tax revenues. It can also make explicit the trade-offs arising from different policy choices. A typical example (illustrated in Chapter 10) shows how a publication on the economics of global tobacco control was instrumental in raising the need for other sectors to become involved in tobacco control.

Finally, the book provides clear examples of powerful forces counteracting the efforts of countries and policy-makers to improve population health and equity. The most robust of these is the tobacco industry's actions to undermine and discredit policy arguments and challenge policy decisions. Examples arising from the alcohol industry are also described. The strategies emerging from the book can be summarized as follows.

- Casting doubt on scientific evidence and misleading the public by denying negative health effects (Chapter 10).
- Promoting ineffective policy solutions. For example, the alcohol industry has promoted corporate social responsibility, a policy intervention that has been proven to be ineffective as the incentives favour irresponsibility rather than responsibility (Chapter 11).
- Permeating and, at times, infiltrating other sectors or decision-making levels by lobbying policy-makers and politicians or recruiting former civil servants with credibility among their peers. Tobacco lobbyists might also reach other sectors – e.g. trying to persuade policy-makers of benefits for tobacco growers' livelihoods or of potential revenue losses after a tax increase – and finally permeate their political discourse (Chapter 10).
- Participating as an actor in the policy arena. Engagement can be negative and, even where positive, often limited or superficial. However, there might be win-win situations with the private sector: for example, in the case of a positive decision resulting from current discussions on introducing a minimum price per gram of alcohol in the United Kingdom of Great Britain and Northern Ireland (Chapter 11).

- Using litigation at national and international levels to challenge policy decisions (Chapters 5 and 10).
- Creating alliances with other business sectors. For example, hospitality, gambling, retail and advertising in the case of the tobacco industry (Chapter 10).
- Moving to countries with least resistance. Markets are dynamic so regulatory efforts in one country can lead to expanding markets in others (Chapter 10). Actors can accept decreases in one region as long as overall consumption of harmful products increases. For example, reductions in North American or some European markets may be compensated for by aggressive marketing elsewhere.

15.2.4 Seizing opportunities for HiAP – bringing together problems, policies and politics

As outlined in Chapter 1, this book set out to investigate the dynamics of policy-making and particularly the interplay between problems, policies and politics. The emergence of windows of opportunity and the conditions for policy-makers to exploit them are central to such a discussion. Examples of several such windows of opportunity opening in response to acute situations and crises (as already noted), or a change in government, include universal health care (30-baht health scheme) in Thailand (Chapter 3) or the case of early childhood development in Chile (Chapter 6).

Windows of opportunity usually open and close quickly so it is important that policy-makers act swiftly when the situation is opportune (Chapter 14). It is essential to be prepared as opportunities can only be seized and used to advance a policy agenda if adequate groundwork has been laid. This can involve longer-term processes of scientific evidence gathering; advocacy and awareness raising; and building of technical capacity. Networks and identified gatekeepers in other government sectors can also facilitate quick reactions when needed.

A sense of strategic thinking and timing are also important. Possibilities for action are shaped by the electoral periods of politicians and the terms of presidents, prime ministers and other high-level government officials, for example. This timing will depend on the political and administrative system of the country but input may be most opportune when parties are preparing for elections and presidents, governments or cabinets are preparing their strategic development plans. Similarly, it is important to know the policy cycles of various administrative processes so that input to them can be provided in a timely manner.

Policies pursued also need to suit the existing politico-economic situation. For example, an increase in excise tax for harmful health products (Chapters 10 and 11) may be more acceptable under conditions of economic austerity when there are pressures to find additional revenue items. Conversely, it may be easier to gain agreement on health-based resource allocation when fiscal revenues are increasing. Progress on most issues discussed in this book occurs through incremental processes that build on evidence, and rely on political and public support at a given time. However, issues are frequently propelled forward at a critical moment in response to the appearance of a window of opportunity.

Finally, national strategies and action plans can be powerful mechanisms to build cross-sectoral consensus on specific policy interventions. When drafted multisectorally and given high political priority, including a structure in high-level administration, such processes can reduce political resistance and create an environment in which to take advantage of any window of opportunity that arises. The cases of several national action plans – such as Namibia's National Policy on HIV/AIDS (Chapter 14); Brazil's National Tobacco Control Programme (Chapter 10); and Malawi's comprehensive national strategy to tackle malnutrition (Chapter 9) – provide examples of policy processes reflecting long-term policy goals and helping policy-makers to be prepared to seize opportunities.

15.2.5 Implementing HiAP

In light of the evidence from the preceding chapters, it is possible to identify several factors that contribute to a successful implementation. These include: early involvement of actors; political support and public participation; careful planning and allocation of responsibilities; legal backing; and the need for complementary interventions. The book also identifies, and suggests ways to overcome, barriers for implementation related to the administrative structure of government sectors.

In policy-making, implementation should be carefully anticipated even before decisions are taken to inform policy-makers on the feasibility of a given implementation strategy. Government actors from whom actions are expected should already be involved in the policy development process, as described in Chapter 6 concerning implementation of early childhood policies, for example. Chapter 5 stresses the need to include health perspectives when negotiating international agreements for trade and investment and Chapter 10 demonstrates some of the consequences of failing to do so.

High-level political support is important, especially for multifaceted problems. This can be concretely expressed, for example, with an explicit legal backing

as in Chile (see below) or by placing the coordinating structure high in the administration. For example, in Malawi the Department of Nutrition, HIV and AIDS is within the Office of the Prime Minister and Cabinet (Chapter 9). In Afghanistan the recognition that potential synergies could be lost through problems in institutional coordination led to activities being merged under the leadership of the Office of the Vice-Presidents (Chapter 9).

Public participation and support is also stressed as a key to success: only policies that have public support are likely to be sustainable (Chapter 8). Civil society involvement in pressure groups and as watchdogs is central in advocating for effective and transparent implementation. As Chapter 2 shows, civil society actors have been key since the foundation of modern public health and their contribution has been crucial in creating and sustaining political accountability in the fields of occupational health, mental health, tobacco and the environment (Chapters 7, 8, 10, 12). Chapter 2 also shows the importance of policy champions during the implementation process, as vital players sustaining momentum in the media, political spheres and at lower administrative levels.

Careful planning and allocation of responsibilities among sectors or responsible departments are critical for successful implementation (Chapter 9). Sufficient human, financial, managerial and technical resources are essential. As illustrated in the case study on Chile's child protection programme, continuous support and communication between administrative levels is important to identify implementation gaps and hear the views of frontline civil servants (Chapter 6). The existence of measurable strategies and cooperation agreements can be useful to materialize the division of responsibilities (Chapter 7).

One important lesson from the book is that HiAP is relevant for countries of all levels of income. This implies that the priorities for HiAP and their implementation strategy would need to be tailored and adapted to levels of social and economic development and implementation capacities that already exist or can realistically be built up. As the book shows, even in resource-constrained settings it is possible to incorporate health across government sectors: policy-makers need to be prepared to consider capacity building as part of the implementation process, ensuring roll-out in accordance with the available possibilities. Chapter 13 suggests that capacity building for HiAP should be considered as an intrinsic part of development assistance for health.

Several chapters point to the need to undertake complementary actions simultaneously across a number of sectors in order to ensure the impact and effectiveness of interventions. Chapter 9 reports evidence that agricultural interventions without other components (e.g. health, water and sanitation, education) have had limited impact. Some chapters note that addressing

gender and other inequalities is critical to maximize the impact of other policy interventions. Chapter 11 suggests that interventions increasing excise tax on alcohol must come together with interventions to reduce illicit or illegal alcohol production. Otherwise, increases in smuggled or home-brewed alcohol may counteract the efforts and result in no improvements for population health. It is also suggested that tobacco control measures should include mechanisms to allow tobacco growers to find other sources of livelihood so that policy solutions interfere less with these farmers' interests (Chapter 10).

Legal backing can also be important, as shown in the experience from Chile (Chapter 6). The imminent risk that the new government would discontinue the early childhood development programme prompted policy-makers to pass a law to ensure its sustainability. Development of national legislation (constitutions, laws, norms and regulations) can find support from international treaties and conventions. However, as well illustrated in Chapter 7, international commitments are not automatically transposed into national law and practice and therefore technical assistance from the relevant international bodies may be needed.

Several chapters note the importance of monitoring and evaluation (e.g. the EDI in Chapter 6). A monitoring system can include epidemiological surveillance on health outcomes and determinants, as well as on policy decisions and their implementation. Such systems are crucial in improving the transparency of policy-making and can facilitate accountability for health in decision-making on, and implementation of, societal policy.

Among the barriers to implementation, the book identifies administrative silos in public administration and particularly within the health sector. These are apparent in the existence of compartmentalized structures of vertical programmes and curative, preventive and promotion activities. Chapter 13 offers an extensive discussion on these challenges in the context of development assistance for health (see also Chapters 8 and 14). Multiple and often conflicting governance structures may hinder multisectoral work, as discussed in Chapter 9. HiAP presents an opportunity within the health sector to foster horizontal means of collaboration as well as networking and communication capabilities.

15.3 Conclusion

It has been known for decades that good health for all cannot be achieved by the efforts of the health sector alone. The Health for All strategy and efforts to implement healthy public policies and intersectoral actions for health have all arisen from this widely shared understanding – at least among health policy-makers. The point of departure of this book is that health and health equity

are worth taking seriously in all societal policy-making. There have been remarkable advances in health, and many efforts across sectors (e.g. education, environment, agriculture) have been instrumental in these improvements, but policy-makers across countries have found it difficult to know how to incorporate health considerations in policies across other fields.

In the context of a dynamic policy process, the book offers a key lesson: the need to be prepared and quick to seize windows of opportunity arising from the convergence of problems, policies and politics. This highlights the need for a long-term strategy and sense of timing: strategy to identify and prioritize the most important health and health equity gaps, policy solutions that can find support at a given time and the key actors and processes; timing to provide input to policy and political processes across government sectors. Another primary aim has been to enhance understanding of how intersectoral policies can be implemented in various settings and why this should be a concern for policy-makers across sectors. This book provides a wealth of fresh evidence to help policy-makers in this endeavour.

Overall, the evidence presented here shows that HiAP is feasible in a variety of fields and countries of all stages of development. As editors of this book, we hope that readers will find it useful for their own work towards better health and health equity.

Glossary

Capacity: "the skills, knowledge and resources needed to perform a function" (1).

Determinants of health: "the range of personal, social, economic and environmental factors that determine the health status of individuals or populations" (2). The determinants of health can be grouped into seven broad categories: socioeconomic environment; physical environments; early childhood development; personal health practices; individual capacity and coping skills; biology and genetic endowment; and health services (3).

Equity: "the absence of avoidable or remediable differences among populations or groups defined socially, economically, demographically, or geographically" (4). This includes the notions of horizontal and vertical equity (see *social justice*).

Governance: broadly concerns the agreed actions and means adopted by a society to promote collective action and deliver collective solutions in pursuit of common goals. Governance can be formed at different levels of social organization – local, state/provincial, national, regional and global – and can become closely intertwined (adapted from (5)).

Health for all: "the attainment by all the people in the world of a level of health that will permit them to live a socially and economically productive life" (6).

Health impact assessment: "a combination of procedures, methods and tools by which a policy, program, product, or service may be judged concerning its effects on the health of the population" (7).

Health in All Policies (HiAP): an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making (adapted from WHO Working Definition prepared for the 8th Global Conference on Health Promotion, Helsinki, 2013).

Health (in)equity: differences in health that are unnecessary and avoidable and, in addition, are considered unfair and unjust (8). The CSDH states that such differences must be systematic and considered avoidable by reasonable action globally and within societies (9).

Health promotion: "the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. An evolving concept that encompasses fostering lifestyles and other social, economic, environmental and personal factors conducive to health" (Ottawa Charter, cited in (10)).

Health sector: "organizations that are held politically and administratively accountable for the health of the population at various levels: international, national, regional and local" (Chapter 14).

Health service: "a formally organized system of established institutions and organizations, the multi-purpose objective of which is to cope with the various health needs and demands of the population" (11).

Health system: "All the organizations, institutions and resources that are devoted to producing health actions" (12).

Healthy public policy: is characterized by "an explicit concern for health and equity in all areas of policy, and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing" (13).

Human rights: "rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. ... All human rights are indivisible, whether they are civil and political rights, such as the right to life, equality before the law and freedom of expression; economic, social and cultural rights, such as the rights to work, social security and education, or collective rights, such as the rights to development and self-determination are indivisible, interrelated and interdependent. ... Human rights entail both rights and obligations. States assume obligations and duties under international law to respect, to protect and to fulfil human rights. The obligation to respect means that States must refrain from interfering with or curtailing the enjoyment of human rights. The obligation to protect requires States to protect individuals and groups against human rights abuses. The obligation to fulfil means that States must take positive action to facilitate the enjoyment of basic human rights" (14).

Intersectoral action for health: actions undertaken by sectors outside the health sector, in collaboration with the health sector, on health or health equity outcomes or on the determinants of health or health equity (adapted from (15)).

Population health: "the health outcomes of a group of individuals, including the distribution of such outcomes within the group" (16). Crucial to the concept of population health is Rose's idea that most cases in a population come from individuals with an average level of exposure (rather than high-risk groups). A small (clinically insignificant) change at a population level yields a greater impact on population health and well-being than an intervention on high-risk groups (17).

Risk conditions: the social, economic, geographical and environmental conditions into which people are born. They encompass the social determinants of health; condition and constrain health opportunities; and are causally associated with an increased probability of a disease or injury, lower self-reported health and with risk factors.

Risk factor: "an attribute or exposure which is causally associated with an increased probability of a disease or injury" (18).

Strategy: broad lines of action to be taken to achieve goals and objectives, incorporating the identification of suitable points of intervention; ways of ensuring the involvement of other sectors; the range of political, social, economic, managerial and technical factors; as well as constraints and ways of dealing with them (19).

Social determinants of health: The WHO CSDH defined this as the circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness. The CSDH took a holistic view of social determinants of health, arguing that "the poor health of the poor, the social gradient in health within countries and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services." Further, it said that "the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries" (4, 20).

Social justice: "is not possible without strong and coherent redistributive policies conceived and implemented by public agencies" (21). Social justice theory is generally associated with European societies and, particularly, with struggles during the industrial revolution and the emergence of socialist, social democratic or other models of redistributive welfare states. On the basis that this theory is essentially concerned with equity or fairness, it is argued that social justice (equity) is a universal concern, since all social arrangements, to be legitimate and to function at all, must attend to issues of equality (22). But there are subtleties to how equity is conceived, set within two main dimensions: (i) equality of opportunity, achieved through procedural justice or 'horizontal equity' in which equals are treated the same; and (ii) equality of outcome, achieved through substantive justice or 'vertical equity' in which people are treated differently according to their initial endowments, resources, privileges or rights (23).

Whole of government: "denotes public service agencies working across portfolio boundaries to achieve a shared goal and an integrated government response to particular issues. Approaches can be formal and informal. They can focus on policy development, program management and service delivery" (24).

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Health in All Policies

Seizing opportunities, implementing policies

Health in All Policies (HiAP) is an approach to public policies across sectors that systematically takes into account the health and health-system implications of decisions, seeks synergies, and avoids harmful health impacts to improve population health and health equity. A HiAP approach is founded on health-related rights and obligations. It emphasizes the consequences of public policies on health determinants, aiming to improve the accountability of policy-makers for health impacts at all levels of policy-making.

HiAP has great potential to improve population health and equity. But incorporating health into policies across sectors is often challenging and even when decisions are made, implementation may only be partial or unsustainable.

This volume aims to improve our understanding of the dynamics of HiAP policy-making and implementation processes. Drawing on experience from all regions and from countries at various levels of economic development, it demonstrates that HiAP is feasible in different contexts, and provides fresh insight into how to seize opportunities to promote HiAP and how to implement policies for health across sectors.

Part I sets the scene with five chapters on the concept and history of HiAP, links between socioeconomic development and health, the social determinants of health, and the importance of preserving national policy space for health in a globalizing world. Part II assesses progress in eight policy areas including early childhood development, work and health, mental health promotion, agriculture, food and nutrition, tobacco, alcohol, environment and development assistance. Part III draws together lessons for the health sector, as well as for politicians, policy-makers, researchers and civil society advocates.

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