

TECHNICAL
SERIES

**ON PRIMARY
HEALTH CARE**

Health in All Policies as part of the
primary health care agenda on
multisectoral action

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Introduction

Forty years after the Declaration of Alma-Ata on Primary Health Care, the Declaration of Astana on Primary Health Care will be released at the Global Conference on Primary Health Care. The conference is being cohosted by the Government of Kazakhstan, the World Health Organization (WHO) and the United National Children's Fund (UNICEF), on the occasion of the 40th anniversary of the Declaration of Alma-Ata.

The conference recommits to strengthening primary health care through the Declaration of Astana on Primary Health Care, and puts forward a vision for primary health care as an approach or strategy for health in the 21st century that orients society and health systems to maximize health and well-being with equity. The primary health care approach is centred on the importance of the needs and circumstances of people, as individuals and communities. People's (primary) health care (1) a term coined by the historian, Professor Anne-Emanuelle Birn, comprises three interrelated and synergistic components (see Fig. 1):

1. Systematically addressing social, economic, environmental and commercial determinants of health through evidence-informed public policies and actions across all sectors;
2. Empowering people, families and communities to take control of their health, as advocates for policies that promote and protect health, as codevelopers of accountable health and social services through social and community participation, and as self-carers and caregivers to others;
3. Ensuring people's main health problems are addressed through comprehensive promotive, protective, preventive, curative, rehabilitative and palliative care throughout the life course. Key services that are responsive to those who are most vulnerable and marginalized aimed at the population (e.g. public health functions) and personal services are the central elements of integrated service delivery across all levels of care.

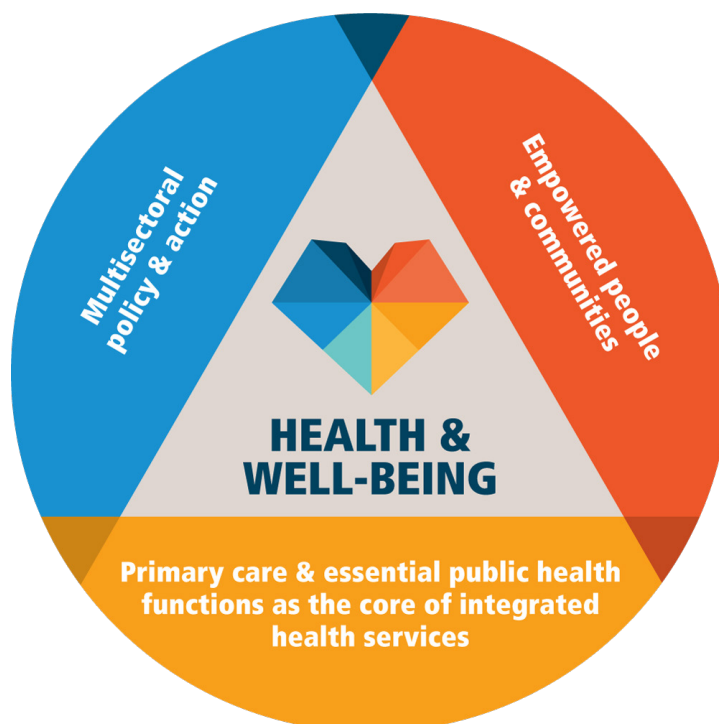


Fig. 1 The components of primary health care
Source: A vision for primary health care in the 21st century, WHO, 2018



The components of the Declaration of Astana are designed to move societies towards universal health coverage and the Sustainable Development Goals (SDGs) (2). The SDGs provide the first comprehensive, consensus blueprint for human development, within which population health is a precondition, an outcome and an indicator of sustainable development (3). Health and the health sector contribute to, and are influenced by, actions taken to achieve all other goals and targets.

This background paper discusses the importance of the Health in All Policies approach as part of the Declaration of Astana in pursuing universal health coverage and the broader SDGs through addressing determinants of health. Health in All Policies (HiAP), defined internationally in 2013 (see Box 1), is a proven approach to address the determinants of health across many sectors by developing the needed leadership and governance and sustained partnerships for actions between sectors.

Box 1 Definition of Health in All Policies

Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity. It improves accountability of policymakers for health impacts at all levels of policy making. It includes an emphasis on the consequences of public policies on health systems, determinants of health, and well-being.

Health in all policies: Helsinki statement (4)

Need to tackle health determinants and use Health in All Policies approaches

Much of the disease burden worldwide is caused by modifiable factors. This means that much of the disease burden and health-related suffering is avoidable. It is not inevitable but arises out of the choices we make, foremost as societies and only secondarily as individuals. Therefore, avoiding disease is determined largely by policies beyond medical care. For example, 15% of all deaths are caused by environmental risks, 22% by dietary risks, 3% by low physical activity and 3% by childhood undernutrition (5).

In addition, classically defined behavioural and environmental risk factors (e.g. tobacco and alcohol use, air pollution, dietary deficiencies, unsafe sexual behaviour) are strongly influenced by complex existing and emerging factors in society, which present challenges to health and well-being in countries and globally. They include rapid urbanization, climate change, pandemic threats, the proliferation of unhealthy commodities, extreme poverty and inequities, and multimorbidity. Many of these challenges have given rise to the increase in noncommunicable diseases (6). Furthermore, different groups in society face different life circumstances; inequities within and between countries are significant. It is imperative for the health sector to enhance traditional public health disease prevention and health promotion functions (7) by tackling the political, social, behavioural, cultural, environmental (physical), ecological and commercial determinants of health – the causes of the causes – through a new wave of public health development (8,9).

Multi- or intersectoral policy and action as a component of primary health care refers to a strategic vision to address these determinants and threats to health. Multi- or intersectoral action for health in this context refers to evidence-informed actions by multiple sectors that are required to bring about the optimal health of a given population. The Lancet report on disease control priorities notes that 15 of 21 essential packages to address priority health issues include a mix of intersectoral prevention and health promotion policies (with 71 in all) and health sector interventions. Essentially, prevention policies are therefore integral to universal health coverage and support successful health services (10).

Prevention and promotion policies for health typically cover four key mechanisms:

1. Fiscal measures such as taxes and subsidies
2. Laws and regulations
3. Changes in the built environment
4. Information, education and communication campaigns.

Proven approaches are needed to bring about these policies. Policy action for health is amenable to HiAP approaches, which build on decades of study of intersectoral action, by adhering to three proven principles beyond evidence-based medicine.

1. The health sector accepts its role as the champion of population health, not solely as curing diseases, keeping health on the agenda of all of government and communities.
2. Broad-based leadership provides political and administrative backing for the health sector to assume this champion role and supports their focus on health and health equity as societal priorities.
3. Work on determinants of health is envisioned as moving away from isolated intersectoral actions towards systematic consideration of the policies and decision-making processes of other sectors.

Without clear commitment to multisectoral policy and action at both the national and district levels, it will not be possible to achieve SDG Goal 3 (Health) or support social inclusion, poverty reduction, equity and sustainable development.



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Changes over time

To understand the renewal of the Declaration of Alma-Ata at Astana and the strong relationship with HiAP, it is useful to consider some history.

Declaration of Alma-Ata: conceptualizing the determinants of health and multisectoral action

The 1978 Declaration of Alma-Ata (11) reflected the “crystallization” of a movement (12) embracing the WHO goal of Health for All by the Year 2000 (13) and revitalizing the focus on the social determinants of health as first suggested in WHO’s Constitution where health is defined as “a state of complete physical, mental and social well-being”. The WHO Constitution also referenced action on the social determinants of health, identifying the Organization’s core functions as including working with Member States and appropriate specialized agencies “to promote ... the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene”, as required to achieve improvements in health (12).

The antecedents of HiAP approaches are clear in the Alma-Ata call for action to address social and environment determinants by and with other sectors. The Declaration of Alma-Ata also makes reference to health inequalities (now more typically referred to as health inequities) and the need for action across all related sectors (11).

The Conference strongly reaffirms ...that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector (11).

The existing gross inequality in the health status of the people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries (11).

Challenge of the Declaration of Alma-Ata: primary health care

Nonetheless, problematic elements to the Declaration of Alma-Ata were identified over time. Primary health care was defined as “essential health care” and the “the first level of contact ...with the national health system”. At the same time it was identified as a “philosophy” of health and emphasized action beyond the health system to address the determinants of health through policies, strategies and plans of action.

All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors (11).

Birn provides a geopolitical perspective on the dashed hopes for Alma-Ata noting the impact of “a (largely orchestrated) Third World debt crisis”; the rise of neoliberal politics; falls in domestic public spending on social welfare worldwide and decreasing commitment to multilateral agencies such as WHO thus curtailing its ability to implement primary health care and challenging its position as a preeminent health authority. The changing and uncertain relations between the former Soviet Union and others increased scepticism and compounded the movement against primary health care. Birn notes “Perhaps the biggest misjudgement on the part of the Soviets – and of WHO – was failure to highlight the role of other sectors in achieving health improvement in the USSR” (1).

Cueto identified four key dilemmas with the notion of primary health care (14), two of which are particularly relevant to this paper.

1. Primary health care has had several meanings – one as the complete reform of public health structures and the new centre of health systems which was undoubtedly challenging to many, and secondly, simply an entry point to the health system, especially for poor people. (To this could be added the (mis)interpretation of primary health care as primary medical care or primary care a medicalized version of the concept.)
2. Poor funding for primary health care limits the capacity to support sustained intersectoral collaboration as it usually attracts public sector rather than private sector investments owing to non-rationality of agents, imperfect markets and other market failures in the production of goods and services with equity, as discussed in welfare economics, whereas medical treatment can be funded through the for-profit private sector (15).



The Alma-Ata commitment to equality, intersectoral action and community participation also posed challenges.

- Countries lacked a commitment to health as a social goal yet this was fundamental to achieving the goals set out in the Declaration of Alma-Ata.
- Relatively few countries had democratic community participation, which is embedded in Alma-Ata.
- The reality of equity in health service delivery was difficult to achieve and not widely agreed.
- Intersectoral action seemed feasible but was compromised without the commitment to economic development through promoting social welfare.
- Other sectors resisted efforts for intersectoral action for health arguing it was difficult to measure the health impact of non-health policies; attribution was difficult as was evaluation of impact.
- There were multiple governance issues with working across sectors including the weak position of the health sector in government (compared with finance and infrastructure for example) and a lack of mechanisms for joint budget approaches (12).

As a result, selective primary health care replaced comprehensive primary care based on the rationale that, whilst comprehensive primary care was “above reproach”, it was unattainable because of the cost and feasibility of getting sufficient trained personnel to provide even minimum basic health services, let alone those envisaged by comprehensive care (16). Thus, an approach based on prevalence, mortality, morbidity and feasibility of control of diseases gained credence.

Notwithstanding the dilemmas, the definition and principles enshrined in the Declaration of Alma-Ata are still pertinent today, including intersectoral action. Kickbusch describes three distinct waves of horizontal health governance with the first focusing on intersectoral action for health (17). Primary health care requires action within and by the health sector, working collaboratively with others to address the determinants of health, achieve improved health outcomes, and in turn, contribute to broader development (17, 18).

Countries that have implemented primary health care have healthier populations, fewer health-related disparities and lower health care costs (see also Box 2) (19). The combination of strong comprehensive health services with an emphasis on actions to promote good health and new policy tools to address the determinants of health provides a foundation to deal with the challenges of the future (as reflected in the SDGs) all of which require action by multiple sectors.



Box 2 Examples of the success of primary health care implementation

Several developing countries (e.g. Costa Rica, Cuba, and Sri Lanka,) made substantial improvements in health and social indicators through policy measures acting on the broad social determinants of health and involving sectors other than health as part of investment in primary health care (12). Strategies are consistent with SDGs such as:

- Making essential food more available and affordable
- Increasing access to education, particularly for women
- Providing access to health care through social security policies
- Improving water quality and sewage control
- Targeting population groups with the poorest health
- Improving labour laws
- Mobilizing civil society participation.

From intersectoral action to Health in All Policies

The idea of addressing the factors that affect population health through action by and with different sectors is not new (20). A comparison of the evolving understanding of the components of intersectoral action and determinants of health—which actors are implicated; the evidence base of health determinants; the practitioner movement (e.g. with definitions and norms of practice) for One Health and HiAP; and the scope for action—provides evidence of this history and informs our understanding of the practice of HiAP today.

Key actors

Although the Declaration of Alma-Ata did not include the term “intersectoral action” or “Health in All Policies”, it made clear reference to the health sector working collaboratively with other sectors to see policy change for better health and development: “primary health care, as an integral part of the health system and of overall social and economic development, will of necessity rest on proper coordination at all levels between the health and all other sectors concerned” (21). Implicit was the responsibility for health sector leadership and the importance of the primary health care sector in enabling this collaboration.

Over time, the scope of the actors required expanded. The 2nd Global Conference on Health Promotion in Adelaide, Australia in 1988 in its recommendations on healthy public policy identified a broad alliance of partners.

Government plays an important role in health, but health is also influenced greatly by corporate and business interests, nongovernmental bodies and community organizations. Their potential for preserving and promoting people's health should be encouraged. Trade unions, commerce and industry, academic associations and religious leaders have many opportunities to act in the health interests of the whole community. New alliances must be forged to provide the impetus for health action (22).

More recently the Shanghai Consensus on Healthy Cities adopted by more than 100 mayors at the 9th Global Conference on Health Promotion affirmed commitments to “prioritize the political choice for health in all domains of city governance and to measure the health impact of all our policies and activities” (23) Today, with 69 of the top 100 economic entities being corporations rather than countries in 2015 (24), the challenge of applying multisectoral approaches to multinational companies is more obvious than ever.

Scope of the determinants of health and health priorities

The nature of the determinants of health and the critical health issues have also changed over time. Multisectoral action was particularly focused on communicable diseases at the time of Alma-Ata reflecting the then burden of disease.





In 1986, the Ottawa Charter on Health Promotion (25) built on the directions of the Declaration of Alma-Ata and referred to eight key determinants ("prerequisites") of health: peace, shelter, education, food, income, a stable eco-system, sustainable resources, social justice, and equity. Importantly, it specifically identified healthy public policy as one of five key actions to promote the health of the population embedding it in health promotion action into the future.

The 1997 WHO Conference on Intersectoral Action on Health: a cornerstone for Health-for-All in the Twenty-First Century in Halifax, Canada illustrated the increasing focus on environmental change and its impact on health, which has continued to gain momentum and expand (26).

The environment has widened further to include the microscopic level of antimicrobial resistance on the one hand and the ecological systems affected by climate change on the other. For example, the conference conclusions and action agenda of the Second Global Conference on Health and Climate, the draft WHO global strategy on health, environment and climate change, and the WHO chemicals road map include increasing reference to HiAP. One Health brings multiple health science professions together working locally, nationally and globally to attain optimal health for people, domestic animals, wildlife, plants and our environment (27).

The Commission on the Social Determinants of Health clarified beyond doubt the determinants of health, health equity and well-being that required action if health is to be improved. Advancing intersectoral coherence in policy-making and action (including for economic policy negotiations and commercial interests) and Health Equity in All Policies was one of the main recommendations of the final report of the Commission in 2008 (28).

More recently the SDGs cover a wide range of determinants and recommend strengthening the means to implement and revitalize partnerships and cooperation (Goal 17) (3).

Need for and scope of policy change

In the Ottawa Charter on Health Promotion that arose from the First International Conference on Health Promotion in 1986, specific types of policy are mentioned – legislation, fiscal measures, taxation and organizational change – similar to those identified recently in the review by Jamieson et al. on universal health coverage and intersectoral action for health (10). The political nature of this work is highlighted; conference participants pledged to advocate a clear political commitment to health and equity in all sectors.

By 2016, the Shanghai Declaration had expanded on this and outlined the role of legislation, regulation and taxation to address unhealthy commodities, fiscal policies to enable new investments in health and well-being, universal health coverage to achieve health and financial protection, and strengthened global governance to respond to cross-border health issues (29).

Partnerships and shared responsibility across sectors and stakeholders, together with civil society, the private sector and communities, are seen as being at the heart of good governance for health and sustainable development. This makes HiAP an essential tool for acting on the SDGs.

Health in All Policies (and One Health): an emerging practice

At around the same time as the Commission on the Social Determinants of Health, Health in All Policies was gaining increasing acceptance as a systematic intersectoral practice through the efforts of the Finnish President of the European Union. A 2006 resolution of the Council of the European Union called for parliamentary mechanisms and health impact assessments to ensure health and health equity were considered in all government policies and actions (30). HiAP is framed as “a horizontal, complementary policy-related strategy with a high potential of contributing to population health” (31). The focus was on the role of policies in setting the direction for health and well-being. Policy refers not to documents but rather to the political science concept of laws, codes, guiding principles, duties, working frameworks and ways of working, both written and unwritten, that guide intended and practised decisions and actions (32).

Over time there has been increasing clarification of what Health in All Policies means. Both the Rio Political Declaration on Social Determinants of Health (33) and the 2013 Helsinki Statement on Health in All Policies promote HiAP as a method for facilitating a more integrated and networked approach to policy-making (4). In 2009–2010, WHO and the South Australian Government cosponsored an International Conference on Health in All Policies which resulted in the Adelaide Statement on Health in All Policies (34). Almost 10 years later, a second conference was held and statement released (Adelaide Statement II) that reflected over a decade of additional practical experience across the world and the clear relevance to the SDGs (35).

The past 10 years has also seen the rise of the one-health approach. Along with HiAP, it is the most formalized approach to addressing health determinants. While developed largely separately, One Health shares most of the core principles of Health in All Policies as applied to zoonoses and the animal–human health interface. It conceives of multisectoral collaboration and multidisciplinary action to address the challenges to public health, animal health (both domestic and wildlife) and the environment through building trust and longer-term partnerships and collaboration. It aims to transform governance of animal health, environment and human health issues by better aligning the policies of all the relevant sectors and disciplines and building the necessary systems, services and workforce capacities.

While the terminology may still be evolving and our understanding maturing, this long history of support for action to tackle the determinants of health, increasingly through the HiAP approach, is testament to its critical importance, its common sense and the imperative to strengthen its implementation.

HiAP requires continuous reinforcement and reiteration because it is not yet embedded as mainstream practice. It is not easy – it requires specific skills to work across sectors, and political commitment to tackle the determinants of health, break down the separated systems and structures and demand integrated responses; at the same time health sector leadership is still inadequate and non-health sectors are still learning.

Health in All Policies and the Sustainable Development Goals

Need for Health in All Policies to address the Sustainable Development Goals: role of the health sector

The SDGs provide a blueprint for human development that aims to leave no one behind. The SDG 2030 agenda covers a range of interdependent challenges with 17 goals, 169 targets and 230 indicators. Goal 3 (Ensure healthy lives and promote well-being for all at all ages) is the domain of the health sector but achieving Goal 3 relies heavily on progress in all other goals; nutrition (SDG 2), violence against women (SDG 5), air quality (SDG 11) and birth registration (SDG 16), to name just a few, are all determinants of health outcomes (36).

This interconnection works in a bidirectional way – improved health outcomes also assist progress towards goals such as no poverty (SDG 1), good-quality education (SDG4) and decent work and economic growth (SDG 8). Healthier people are better able to access education, be informed on issues, make decisions for the health and wellbeing of themselves, their families, their communities and their environments. Healthy people find jobs more easily, learn more successfully and contribute to economic development. Essentially all the SDGs influence – and are influenced by – health. A focus on health promotion will create a more active, empowered and engaged community. Box 3 illustrates how actions to support good health are similar to the steps to support healthy physical and social environments.





Box 3 Connecting healthy people and the Sustainable Development Goals

The type of strategies typically used to promote healthier people and environments (informed by the Ottawa Charter) can also be used to tackle many different social challenges, for example environmental issues, social problems such as violence against women, and even extreme weather events.

- Healthy public policy – the focus of this paper – involves creating policies that support health and well-being in finance, social welfare and education, among others. Policies on financial risk protection in particular are critical to allow people to move out of poverty
- Creating healthy places where people live, work and play creates environments which are safe and supportive
- Building personal skills enables action by individuals on any number of issues such as healthy eating or quitting smoking, preparedness for bushfires, employment, parenting
- Strengthening community action can help engage the community to take action on social and environmental issues such as recycling, unhealthy workplaces or discrimination of minorities
- Reorienting health services towards the promotion of good health and prevention of illness reminds us that health services have a key role to play in building stronger communities, as well as reminding us that health facilities need to first do no harm, either to patients or health workers, and therefore be equipped with the appropriate water, sanitation, and energy supplies and safe equipment.

This connection is mirrored in the action agenda of the Second Global Conference on Health and Climate (37), which identifies the interrelatedness of climate and health. A core aspect of the approach is a focus on areas of synergy between health and other goals through partnership.



Health in All Policies: a transformative approach to the Sustainable Development Goals

The inseparability of health, environments and sustainability reflected in the SDGs is clear and this requires work across sectors. Why is HiAP the best approach?

HiAP offers a transformative approach that builds partnerships through systematic and coordinated engagement. It addresses the complexity of challenges including the stakeholders, vested interests, politics and people involved (38). Whilst it is possible to make progress on the determinants through ad hoc intersectoral strategies, or by focusing on intermediate determinants of health, HiAP offers a focus on policies that shape behavioural determinants, for example, and a way of working that explicitly aims to help other sectors achieve their goals whilst simultaneously working to improve health outcomes. This minimizes the tendency towards “health imperialism”—health imposing its views and priorities on other sectors. One-off approaches to multisectoral work make it difficult to build the required level of trust for success. Sustained partnerships require codesign and a shared understanding and common purpose built up over continuous interactions that are systematically supported and resourced. Such an approach needs to be institutionalized and supported by adequate governance mechanisms to be transformative and sustainable.

As defined, HiAP is an approach to public policies that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity. It is underpinned by partnerships with other sectors whose policies and practices affect the factors that determine health (in) equity, including poverty, education, stigma, housing and access to services. Whilst health and equity may not be a policy priority for other sectors, HiAP seeks benefits across sectors based on the understanding that health and health equity are important in their own right and prerequisites for achieving other social goals. HiAP provides a means to protect the health of populations against unintended public policy consequences that are detrimental to health.

Developing a sophisticated multisectoral understanding of inequity and its implications for the whole population, groups at risk and the economy takes time and a close and trusting relationship. HiAP, which includes the other formalized approach, One Health, offers the means to do this.

Table 1, extracted from the WHO 2017 World Health Report, provides an overview of some of the key linkages between goals and examples of the mutual gain from policies that align health goals and those of other sectors. Importantly the SDGs include a strong environmental sustainability focus across all the goals, including three SDGs devoted to climate action, life on water and on land.

Table 1 Examples of opportunities for leveraging intersectoral actions to improve health and achieve other targets of the Sustainable Development Goals

Exposure	Key health outcomes	Intersectoral action: examples of key sectors beyond the health sector	SDG targets
Inadequate water, sanitation and hygiene	Diarrhoeal diseases, protein-energy malnutrition, intestinal nematode infections, schistosomiasis, hepatitis A and E, typhoid and poliomyelitis	Actions by water and education sectors to improve management, affordability use of appropriate technologies, while empowering communities; actions of the water sector to ensure supplies to health facilities	1.4; 4.1; 6.1; 6.2; 16.7
Poverty and food insecurity	Under-five child deaths, stunting and wasting	Social welfare cash transfer programs to reduce poverty and improve child nutrition and use of preventive health services	1.1; 1.2; 1.3; 2.1; 2.2; 10.4
Air pollution	Cardiovascular diseases (CVDs), chronic obstructive pulmonary disease (COPD), respiratory infections and lung cancer	City governments, the energy, industry and transport sectors addressing urban design and transport systems result in multiple health and environmental benefits	7.1; 7.2; 9.1; 11.2; 11.6; 13.1
Substandard and unsafe housing, and unsafe communities	Asthma, CVDs, injuries and violence deaths	Housing and urban planning sectors ensure housing standards that reduce homelessness, promote health and address sources of air pollution	1.4; 5.2; 7.1; 7.2; 9.1; 11.1; 11.6; 12.6; 16.1
Hazardous, unsafe and poor work environments	COPD, CVDs, lung cancer, leukemia, hearing loss, back pain, injuries, depression, among others	The labour sector promotes occupational standards and worker's rights to protect worker health and safety across different industries (including the informal economy)	8.5; 8.8; 12.6; 13.1; 16.10
Exposure to carcinogens through unsafe chemicals and foods	Cancers; neurological disorders	Sound management of chemicals and food across the food industry, agriculture sector, and different areas of industrial production	6.3; 12.3; 12.4
Unhealthy food consumption and lack of physical activity	Obesity, CVDs, diabetes, cancers and dental caries	Improving product standards, public spaces, and using information and financial incentives involves the education, agriculture, trade, transport, and urban planning sectors with benefits for social inclusion and the environment	2.2; 2.3; 4.1; 9.1; 12.6
Inadequate child care and learning environments	Suboptimal cognitive, social and physical development	Specific early child development programs designed by the health and other sectors, with supportive social policies (for example, paid parental leave, free pre-primary schooling and improvements in female education)	1.3, 4.1; 4.2; 4.5; 5.1; 8.6; 8.7

Source: World health statistics 2017: monitoring health for the SDGs, Sustainable Development Goals (39).

The list of 71 intersectoral interventions recommended by experts referred to earlier provide further specific examples on issues such as financing policies on school feeding programmes, product labelling of salt and sugar content, regulation of building codes for adequate ventilation to reduce air pollution, restriction of access to contaminated sites and a range of traffic safety initiatives (40). The HiAP approach supports coherence in policies to tackle such challenges.



Role of primary health care and universal health coverage

The Declaration of Astana highlights that primary health care is a necessary foundation to achieve universal health coverage because it is the most effective, efficient and equitable way to improve health. As noted in the Introduction, a key action area in the Declaration is to systematically address the broad determinants of health through evidence-based public policies and actions across sectors.

Further, the SDGs intention to “leave no one behind” places equity front and centre. This applies to SDG 3 – ensuring service delivery, particularly primary health care services, are accessible to all and particularly groups at the greatest risk and with the poorest health – as well as other SDGs. Equity is reflected in the Declaration of Astana which argues for primary health care that emphasizes equity, quality and efficiency.

HiAP offers an evidence-based approach for use by the primary health care sector to raise awareness of inequities in health and well-being and advocate for public policies to address the determinants. In particular, health partners are central to achieving the SDG: Enhance policy coherence for sustainable development (SDG target 17.14) (18).



Access to good-quality and affordable health care is a key determinant of health. Quality care can only be provided if health facilities themselves have adequate basic amenities such as water, sanitation and energy, as mentioned earlier. Universal health coverage is a priority objective of WHO and is a specific target within SDG 3 (SDG target 3.8).

Universal health coverage is defined as ensuring that all people have access to needed health services (including prevention, promotion, treatment, rehabilitation and palliation) of sufficient quality to be effective while also ensuring that the use of these services does not expose the user to financial hardship (41).

Primary health care provides a means to provide this care whilst also encompassing action to address the broader social determinants of health and support community participation – making it people's (primary) health care (1). To manage and promote population health and health equity, multisectoral actions, using HiAP as an approach, are necessary to deliver on universal health coverage and the SDGs [see the remarks of WHO Director-General Tedros Adhanom Ghebreyesus (42)].

There's an important distinction between universal health care and universal health coverage. The former is often used to refer to clinical services delivered by health workers in health facilities. The latter includes clinical services but is much broader: It also includes public goods that address the social, economic, occupational and environmental determinants of health, such as clean water and sanitation,

road safety, efforts to reduce air pollution and so on. Many of these are determined by policies that lie outside the health sector, so it's vital that those of us in the health sector work across sectors to achieve health goals, such as working with the energy sector to improve reduce air pollution and climate change. In the same way, other sectors need to work with the health sector to achieve their own goals (42)

Primary health care ensures interaction between the health sector, other sectors, and individuals and communities to deal with the main health problems and address the broad determinants of health. This applies to practitioners understanding and addressing the social circumstances of individuals as well as their health needs, and a population health “management” response to promote health and prevent illness and injury. This is not possible without partnerships with other sectors (See Box 4 for an example).

Box 4 Multisectoral action at different levels – an example

Consider the problem of drug and alcohol abuse. As well as helping the individual, local health services need to work with schools, local governments (e.g. to establish alcohol-free zones), the police and services that provide legal, employment and relationship support. However, local collaborations will not usually be sufficient to tackle the problem in a comprehensive way and prevent further issues. This will require macro-level policy reforms, again with multiple sectors involved to ensure appropriate policy is developed. Thus, policy reforms at national, regional and local levels complement the types of health services the population experiences. Health in All Policies offers a methodology for use at both the local and the macro level to achieve health-promoting and health-protecting policy changes.

HiAP must operate at the national and central government level but can and should be applied at the local level, drawing on different parts of the health workforce, including the environmental health workforce and other allied professionals working to protect and improve population health. How it is applied will influence the population's experience of the first level of health services as well. Local work can take many forms: local strategic partnership agreements and collaborations; encouraging health promoting environments; inspectorate functions; and joint commissioning. It will require different tools, e.g. health impact assessments, community budgets, staff exchanges and networks. These need to be supported by training and development, evidence, data and other information, and evaluation tools. The priorities typically are key health and health-related issues including housing, community safety, travel, urban planning and stronger communities (43). As an example, multisectoral commitment to the provision of water and sanitation facilities in communities could include subsidies for vulnerable groups combined with education programmes to develop skills, and provide building and infrastructure upgrading through investments in local suppliers.

In summary, improving health equity and health outcomes requires action on multiple fronts – within health and with sectors beyond health, at local, regional, national and international levels – led by and/or supported by the health sector. Whether HiAP as a focus of work stands alone as complementary to primary health care or is integrated with primary health care and universal health coverage will vary across countries; the important thing is that it achieves the prominence it deserves and has the organizational models to support implementation.

Implementing a Health in All Policies approach in countries

There is now accumulated knowledge and experience on implementing HiAP which have come from actions taken at country, local and service levels. This section provides an overview of this implementation experience and the key components of action.

The HiAP framework for country action (4) provides guidance to countries wishing to apply HiAP in decision-making to optimize cobenefits with a view to achieving positive health and sustainability outcomes, addressing the determinants of health and reducing inequities.

Putting Health in All Policies into action

Six components have been identified in order to put HiAP into effective action in a systematic way.

1. Establish the need and priorities for HiAP action. This includes ensuring high-level political commitment to act, identifying partners that can influence action, building a case for action based on evidence and health information, and prioritizing actions.
2. Identify supportive structures and processes. Such structures and governance arrangements are critical to success but will depend on local arrangements which may exist or need to be created. Levers, such as treaties and memorandums of understanding, can foster collaborative partnerships and multisectoral mechanisms. Examples include commissions, interdepartmental committees, networks or taskforces.
3. Frame the planned action. Identifying data, relevant plans and policies, setting objectives, identifying resources and developing strategies are key to this codesign stage.
4. Facilitate assessment and engagement. In addition to assessment of the effect of the proposed strategies on health and well-being, engagement with all relevant actors, both within government and beyond, is essential throughout the process. This is critical to ensuring cobenefits, successful navigation of political pathways and positive working relationships.
5. Build capacity. Promoting and implementing action across sectors requires particular skills that need to be developed and fostered in both the health sector and partner sectors. Organizational capacity also needs to be developed, including policies, funding arrangements and working practices, that facilitates action across sectors.
6. Ensure monitoring, evaluation and reporting. This is critical to building the evidence base for HiAP and requires collaborative identification of meaningful shared indicators at all phases of the collaborative process. The health sector has an important role in monitoring and evaluation to ensure positive health and well-being outcomes.



These components are interrelated, iterative and not always sequential (see Fig. 2 with examples provided in Box 5).

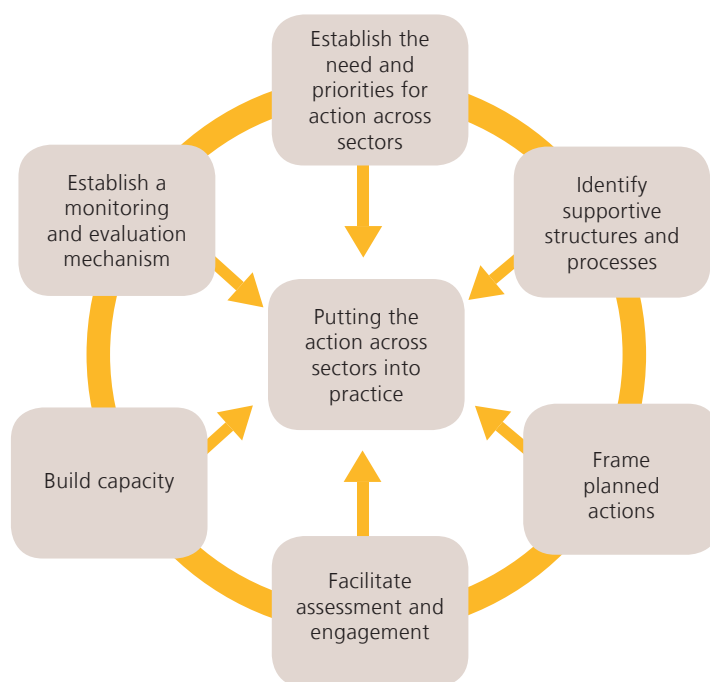


Fig. 2 Key components of implementing health action across sectors

Source: Adapted from the Health in All Policy: framework for country action (4)



Box 5 Examples of starting points for Health in All Policies

Health in All Policies (HiAP) action can take a number of forms large and small and work from different starting points towards a systematic approach covering multiple determinants. Some examples of starting points are illustrated below (44).

- Following increased interest in environmental sustainability, an HiAP task force is created by executive order in order to build interagency partnerships across State government to address health, equity and environmental sustainability (California, United States of America)
- A policy-level health impact assessment is conducted following a natural disaster (Canterbury, New Zealand)
- A health act offers a new form of governance that brings together people, academia and government officials. People focus on how the conditions of their lives affect their health in national health assemblies and this provides greater impetus for health agents to liaise with different agencies across government (Health – Thailand, Well-being – Wales)
- A multisectoral HiAP plan of action is developed and signed up to by the highest level of government related to the issue; a health authority initiates the action, which involves one or more sectors, and has a focus on health and health equity (Sudan)
- Multiple ministries sign agreements to work together with the ministry of health for a joined up policy to implement national development plans (Zambia)
- Key personnel from a range of governments and sectors are supported by WHO to attend HiAP regional and national trainings, facilitating advocacy and building skills; a team is established to drive HiAP action (Saudi Arabia, Namibia, Suriname)



Initiating Health in All Policies

The rationale for HiAP will depend on the context and an understanding of the local policy and political environment but the following suggestions are drawn from international experience.

- Position HiAP in the context of the SDGs – these are a driver for action on the social, economic and environmental determinants of health
- Be opportunistic – look for policy windows, research results, new programmes to get started or move to the next stage
- Seek cobenefits and define shared goals – position health as a major contributor to the economy, greater equity, social cohesion and other societal priorities
- Find the right entry point for your situation, e.g. visiting speakers, new strategies
- Build on what exists – e.g. work on existing agendas but with an HiAP approach so it is less threatening
- Find HiAP champions to kick-start HiAP implementation and provide ongoing support (45).

The important point to understand when initiating HiAP is that multisectoral actions encompass both a political and technical agenda (46). This is why there needs to be sufficient focus on the sociopolitical economy and governance, related to both formal and informal mechanisms. This focus helps to understand why existing multisectoral committees may not be used effectively, and provides a new outlook to design an approach that can be more successful (47).

Implementing Health in All Policies

The Adelaide Statement II reinforces key features of HiAP implementation (35). No matter how or where the multisectoral collaboration begins, HiAP works best when a combination of factors are in place: good governance, strong and sound partnerships based on codesign (see Table 2), dedicated capacity and resources and use of evidence and evaluation.

Table 2 Strengths of Health in All Policies in practice

Strengths of Health in All Policies	Key features
Governance	• an authorizing environment from the highest levels of government • political and executive leadership as well as leadership at all levels of the hierarchy and horizontal leadership • leveraging decision-making structures • creating an environment for cultural change in practices and ways of working • leadership that looks outwards, encourages dialogue, supports experimentation and innovation, and develops a clearly articulated and shared vision
Ways of working across government and society in strong and sound partnerships	• codesign, coproduction and collaboration to achieve shared goals and realize cobenefits • dialogue and systematic consultation • diplomacy to build constituencies to support change, shared measures, and reporting and public accountability with action based on evidence (jointly constructed or with cross-sectoral relevance) • learning-by-doing • reflecting on practice and responding to changing contexts

Source: Adapted from Adelaide Statement II (35).

Systems for HiAP also rely on:

- Dedicated capacity and resourcing. HiAP cannot operate successfully without adequate policy and funding commitment to health promotion and prevention as well as support for the HiAP action. If there is no health promotion infrastructure, including expertise, services, policies and leadership, it is not easy to establish HiAP successfully.
- Use of evidence, evaluation and research. A commitment to investing in health research and evaluation (focused on health policy and health service, not just clinical practice) is needed as this underpins the support functions for HiAP. Data and information are often the basis for advocacy for multisectoral responses.

Sustaining Health in All Policies

Keeping health determinants always in mind and working across different sectors requires constant efforts to maintain the political momentum and build technical capacities. Box 6 provides examples from different countries and different contexts where HiAP is being sustained (18).



Did you wash your Hands?

and washing stops the
spread of germs



Box 6 Health in All Policies in practice (18)

California established its Health in All Policies (HiAP) Taskforce by executive order of the Governor and there has been consistent government leadership support since 2010. A dedicated HiAP team facilitates action to tackle climate change, obesity and other complex issues.

Quito in Ecuador has an enabling legal and policy environment including Metropolitan Ordinance 0494 that empowers partnerships at the district, national and regional level, with corporations and communities.

Thailand has a National Health Act that sets out a framework for participation by the government sector, academia and civil society to tackle the structural problems that affect health through participatory public policy reforms. Codesign has underpinned action on SDGs 5 (gender equality), 6 (clean water and sanitation), 7 (affordable and clean energy) and 11 (sustainable communities) amongst others, through their national health assembly resolutions. Community voices help shape the action on determinants of local importance.

New Zealand's experience in Christchurch showed that joint training and presentations, capacity-building, and meeting and working together strengthened relationships and trust. The health sector made use of evidence and evaluation that was essential to building a successful partnership.

Finland is developing a new model that builds on the commitment of different sectors to take into account the impact of their decisions and actions on health and well-being and further promote equity. As circumstances have changed over time, HiAP implementation has required agility in adapting its methodology and focus.

China has set out 13 core indicators across policy sectors against which implementation of their Healthy China 2030 Plan will be monitored.

A number of countries have made the most of champions including South Australia (Prof Ilona Kickbusch) and sharing lessons learnt.

Monitoring and evaluation are important for justifying and scaling up action. In the long term, the systems and policy changes that are envisaged would cover such things as: reporting and laws in parliament that include criteria for health; increased numbers of impact assessments (including human rights); changes to media reporting; discussion of determinants of health in citizen health forums and other citizen organizations; changes to the education system; and interlinked data on health determinants.

However, in the short-term, evaluations that can sustain partnerships and expand action across different sectors will be very important. As HiAP impacts are often long-term, it is important to evaluate the success of intersectoral partnerships in the short-term. Such evaluations can inform and sustain partnerships and may include indicators related to:

- Increased awareness and understanding of social determinants of health
- Personal and collective learning
- Well-functioning multisectoral collaboration mechanisms, with routine involvement of senior officials, supported secretarial functions
- Broadened perspectives on issue in different sectors
- Convergence of agendas and agreement on action
- New and strengthened alliances and opportunities
- Increased organizational and personal capacity for intersectoral work
- Legitimizing proposed actions
- Reduction in “silo” mindset and processes
- Understanding of each other’s language and processes
- Forums for joint work.

Conclusion

Primary health care has long been understood to include action on the broad determinants of health through public policy changes and partnerships across all sectors. Experience from a growing number of places shows HiAP is a feasible, tested approach to achieving such partnerships and achieving policy change to address the complex challenges to health and well-being that all countries face. There is a growing body of evidence that informs the type of governance, organizational models and functions that underpin successful HiAP. In combination with comprehensive health services and empowerment, the foundations for change will be strong.

HiAP examples show that within-country funding, organizational structures, lead agencies, and ministry arrangements vary from place to place. But what is particularly important is leadership, champions, codesign, capacity, adaptability and expertise to achieve multisectoral action for better health outcomes.

The renewed focus on primary health care together with the SDGs provides an opportunity for these important concepts to be further strengthened by aligning action to ensure that no one is left behind.

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