World Health Organization

TECHNICAL SERIES
ON PRIMARY HEALTH CARE

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

Acknowledgements

This document was produced as part of the Technical series on primary health care on the occasion of the Global Conference on Primary Health Care under the overall direction of the Global Conference Coordination Team, led by Ed Kelley (WHO headquarters), Hans Kluge (WHO Regional Office for Europe) and Vidhya Ganesh (UNICEF). Overall technical management for the Series was provided by Shannon Barkley (Department of Service Delivery and Safety, WHO headquarters) in collaboration with Pavlos Theodorakis (Department of Health Systems and Public Health, WHO Regional Office for Europe).

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We also acknowledge a number of members of the UHC2030 Multisectoral Action Technical Working Group who contributed to this document: Justin Koonin (ACON), Emmanuel Odame (Ministry of Health, Ghana), Toomas Palu (The World Bank), Tricia Petruney (Pathfinder International), Carmel Williams (Government of South Australia) and Shehla Zaidi (Aga Khan University, Pakistan).

The views expressed in this document do not necessarily represent the opinions of the individuals mentioned here or their affiliated institutions

This publication is also published as part of the WHO Discussion Paper Series on Social Determinants of Health, no. 11.

WHO/HIS/SDS/2018.59

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.

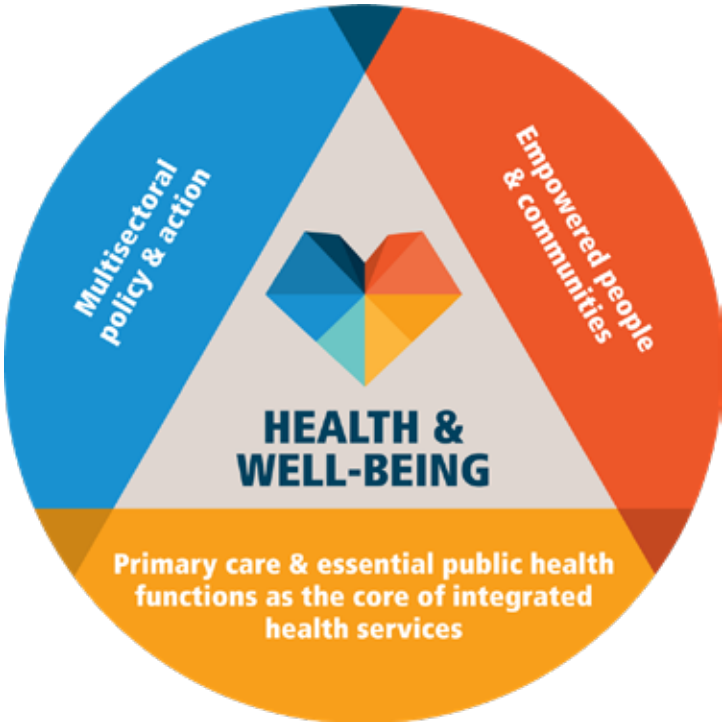

Fig. 1 The components of primary health care
Source: A vision for primary health care in the 21st century, WHO, 2018

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.

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).*