



GLOBAL GOVERNANCE FOR HEALTH: HEALTH IN ALL POLICIES

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Health is the number one priority for all families. And it should be the number one priority for all governments. But all too often health is seen as a ‘sector’, the responsibility of a single ministry. Typically the Minister of Health finds it necessary to convince the Ministry of Finance of the importance of the health ministry’s budget, in competition with all the others.

This narrow economic view is problematic for two reasons. One is that it is based on, and encourages, a view of the world that is driven by a purely economic logic. The other is that it tends to conceal the reality that health outcomes are not solely – or even mainly – the result of the actions of the Ministry of Health but rather the outcome of actions in all sectors.

Hence the need for ‘health in all policies’ which should be a guiding principle not only at national but also at global level, as I shall be discussing in a moment. I strongly believe that when the question is “What works” in development, a “health in all policy approach” is an important part of the answer.

In seeking to correct the present day situation, and place health in the foreground, health indicators have proved, in recent decades, to play an important role. Here I shall refer briefly to two significant cases.

The first is the use of human development indicators in the Human Development Reports of the United Nations Development programme (UNDP), published annually since the year 1990.

The inspiration for these came from a Pakistani economist, Mahbub el Haq, with support not least from Amartya Sen. The simple but crucial insight was that income per capita is an inadequate measure of people's wellbeing. The human development indicators widened the measure of well-being to include also health and education. This had the merit of reducing the excessive focus on income, and drawing attention more to people's health, measured in terms of life expectancy or infant mortality – just to name two examples.

In brief, the efforts of the Human Development Report teams made a significant contribution to placing health higher on the national and international agenda. The second initiative I would draw attention to in this connection is the work of the Commission on the Social Determinants of Health. To quote from their report, entitled 'Closing the gap in a generation: Health equity through action on the social determinants of health':

Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others.

The report makes creative and very effective use of health indicators to demonstrate how extreme are the health inequities that we face today: at global, national and local levels.

The social gradient that is so starkly revealed by these indicators is apparent even within a single city, as Sir Michael Marmot, the chair of the Commission, has written:

In about 25 min I can cycle from Somers Town, just north of University College London, to Hampstead, a little way further north. The life expectancy gap between men living in these two areas is 11 years. ... the population is ranged along the spectrum from life expectancy of 70 years for men in Somers Town and St Pancras to 81 years for men in Hampstead.

Based on rigorous epidemiological evidence and analysis Marmot shows that inequalities in health arise because of inequalities in the condition of daily life and the fundamental drivers that give rise to them: inequities in power, money and resources. Marmot argues that there is a close link between social economic features of society and the distribution of health among the world population – so close a link that the magnitude of health inequalities is a good marker of progress towards a more just world. A group within the World Health Organization takes Marmot's analysis a step forward showing how measuring health can tell us how well development is advancing the three pillars of sustainability: social, environmental and economic. I will name two examples: Many food related diseases and conditions, such as under-nutrition, micronutrient deficiency, obesity as well as food safety risk and farmworkers' health are interlinked. The group argues that sustainable food policies that place the promotion and protection of health at the core of strategies from the farm to the plate can help advance the provision of sustainable food production, and access to quality foods for all. The second example: More than two thirds of the world population will be living in cities by 2050. The rapid rate of urban growth creates enormous challenges. While cities concentrate opportunities they also concentrate health risks. A recent expert assessment estimated that in 2010 outdoor air pollution caused 3.3 million deaths annually. Progress can be directly measured with the burden of air related diseases and injuries.

In other words, measuring health can be a powerful tool in policy formulation. Noting that life and health is our most important asset and interlinked with the most pressing issues of our time, The Oslo Ministerial Declaration (2007) stated that there is an urgent need to broaden the scope also of foreign policy. Together, we face a number of pressing challenges that require concerted responses and collaborative efforts. These challenges cannot be solved at the national level alone but needs concerted collective action and new paradigms of cooperation.

As I mentioned in the beginning: health should not only be the number one priority for all families, but also for all governments – and for all ministries. The health minister can do so much more to protect and promote people's health if backed by fellow ministers that are duly attentive to the health impact of their policies.

The idea of intersectoral action for health is not new – and was a key strategy of the Alma Ata Declaration in 1978, which encouraged the health sector to look beyond its role of acute medical care and to consider how to deal with the root causes of people's ill health. Since then, many have advocated for addressing the key determinants of health through a systematic rather than sectoral approach.

The World Health Assembly Resolution, *Reducing Health Inequities through Action on the Social Determinants of Health* (2009), challenges governments to improve their efficacy in tackling the determinants of health inequities through a Health in all Policies approach, and for WHO to provide the necessary assistance to enable this action. Many countries, like Norway, Australia, Finland, France and Thailand, have started working towards more integrated policy for health – among others by applying health impact assessments and health lens analysis.

However, it is easier said than done to implement health in all policies. In a report published in 2010, Director of the Graduate Institute of International and Development Studies, Professor Ilona Kickbusch, and Director of South Australia's Department of Health, Dr. Kevin Buckett, outlined some of the issues associated with a health in all policies approach:

“Understanding and dealing with the socioeconomic determinants of health is difficult because issues such as income, employment, education and environment are complex and multi-factorial. The time between cause and effect is generally long (especially compared to the political cycle), evidence is often incomplete or weak, and associations are often difficult to explain.”

Working across government sectors is also difficult—‘ownership’, funding, reporting arrangements, departmental or agency culture, and language all present challenges for joined-up government. Government departments are often said to operate as ‘silos’, which need to be bridged to achieve joined-up government. In reality, government departments often work more like castles and keeps than silos, being actively defended

to resist distraction from ‘core business’ and sectoral interests» (in “Implementing Health in All Policies – Adelaide 2010”).

Thus, one important issue that arises when trying to implement a health in all policies approach, and one that I would like emphasize, is that of power dynamics and relationships between health and other sectors or actors. Who will take the lead – and who will follow?

The issue of power asymmetries was addressed as a key impediment to health equity by The Lancet – University of Oslo Commission on Global Governance for Health. Its report demonstrated how the interests of powerful private actors, such as transnational food and tobacco corporations, and public international organizations and agencies, such as World Trade Organization and the International Monetary Fund, often conflict with public health goals. Too often, health and wellbeing are subordinated other societal objectives, such as economic growth. And too often, it is the livelihoods of already disadvantaged population groups that are most severely affected - contributing to rising inequalities.

Institutionalised power asymmetries challenge collective action across both national and global policy making areas, and effectively hinder the realisation of global and national governance for health. The Commission identified five ‘dysfunctions’ in the current system ...

- **Democratic deficit:** insufficient inclusion of certain actors (such as civil society) in global decision-making processes, and inadequate information transparency to enable meaningful public input.
- **Weak accountability mechanisms:** insufficient means at the global level “to constrain power and make it responsive to the people that it affects, especially people who tend otherwise to be marginalized and silenced” (Scholte, 2010, p. 15).
- **Absent or nascent institutions:** the total or near absence of international institutions to protect health in some issue areas. Examples of such ‘missing institutions’ may be treaties, standards, funds, courts, or softer forms of regulation such as norms and guidelines.

- **Weak institutions to protect health within other sectors** ("sectoral challenge"): inadequate mechanisms to protect health in policymaking arenas outside the health sector, particularly problematic when health is subsumed under other objectives, such as economic or security goals.
- **Institutional "stickiness"**: inflexible norms, rules and decision-making procedures that are resistant to evolve or adapt to changing needs. Such stickiness can lead to inequitable health outcomes when existing rules are harmful for health and/or when they preserve and sustain entrenched interests and power disparities

Faced with such massive challenges, how can I be optimistic about the future? How can I suggest to include 'health in all policies' as an example of what works in development policy? There are two reasons.

he first is because there is evidence that the world is changing. The report of the Commission on the Social Determinants of Health, and our own report which analysed the political determinants of health, show very clearly that the global community is more willing than before to be explicit about the political origins of health and more determined to do something about it. Civil society and NGOs such as the People's Health Movement are very vocal and focused in their efforts to bring about change. Academics and professionals have also become more engaged – manifested perhaps most impressively by the commitment shown by The Lancet. I am very heartened too by the response to our Commission's proposal to establish an Academic Monitoring Panel on global governance for health, to follow up the Commission's work. Through carrying out and inspiring high quality research and analysis, we foresee that the Panel will help instil the much needed awareness that mitigating health inequities is a matter of political choice. Our commission has, if anything, been criticised for not being ambitious enough in this regard. This is clear evidence of a willingness to identify and attempt to counter powerful forces, and powerful actors, that have in the past acted as major constraints to progress.

My second reason for optimism is a concrete example of what has already been achieved by those willing to address and counter these forces, namely the anti-tobacco movement.

The widely applied ban on smoking is a very good example of “what works in development?” with regard to intersectoral action for health. The positive health effects of smoke-free legislation have been found to be immediate and include a reduction in the incidence of heart attacks and improvements in respiratory health.

Currently, 17 EU countries have comprehensive smoke-free laws in place. Also at the global level, there is growing support for reducing tobacco use and secondhand-smoke, clearly evident from the World Health Organization Framework Convention on Tobacco Control (WHO, 2005). The treaty has become one of the most rapidly and widely embraced treaties in United Nations history.

The global Convention represents a milestone for the promotion of public health and provides new legal dimensions for international health cooperation. The achievements made with regard to smoking can surely also be repeated in other areas too.

Let me conclude by returning to my starting point. Health is a powerful indicator of national development and personal wellbeing. It is sensitive to the way we shape and organize our societies and the political choices we make. I expect and hope that health can and should serve as a rallying point for a more sustainable development.