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From Health in All Policies to Health for All Policies

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Worldwide responses to the COVID-19 pandemic have shown that it is possible for politicians to come together across departmental boundaries. To this end, in many countries, heads of government and their health ministers work closely with all other ministries, departments, and sectors, including social affairs, internal affairs, foreign affairs, research and education, transport, agriculture, business, and state aid. In this Viewpoint, we build on the Health in All Policies approach by which the Sustainable Development Goals (SDGs) support intersectoral collaboration to promote health but argue that this relationship should be bidirectional and that health enables the attainment of other SDGs—Health for All Policies. We contend that strengthening health policies and improving health outcomes have major and tangible co-benefits for other sectors.

From Health in All Policies to Health for All Policies

The Health in All Policies concept was first introduced in health policy circles in 2006. Its promise is attractive and straightforward: all sectors should work together to improve health, for example through urban design that encourages walking and cycling, or through education that enables people to make informed choices when these exist. According to WHO, “One in eight deaths is linked to air pollution exposure – mostly from heart and lung disease, and stroke” and “To tackle air pollution, a health ministry cannot act alone.”¹ From this example, it follows that collaboration between many other sectors is needed (eg, energy, urban planning, transport, industry, and health). The Health in All Policies approach uses this relationship between health and other sectors, and it allows the health sector to promote health and initiate dialogues to keep health on policy agendas, thereby generating co-benefits (ie, outcomes that benefit all sectors involved).

Tools such as the Health Impact Assessment have been developed and deployed to inform and assess Health in All Policies, and governments worldwide have issued plans that incorporate Health in All Policies precepts,² although implementing them has not always been simple. Still, we now know much more about the political, professional, and bureaucratic challenges and how to overcome them, from basic problems of conflicting accountability and organisational inertia to the difficulty of coordinating policies among many stakeholders.^{3–5} The mutual benefits are increasingly apparent, with examples of how the concept of Health in All Policies can contribute to increased investment in poverty reduction, education, and urban development.^{6–8} Looking forward, an approach that incorporates Health in All Policies is the only way to achieve the health-related goals governments are pursuing. Otherwise, health systems will remain locked in a never-ending struggle as they respond to the ill health that often arises from weaknesses in other sectors.

However, engaging other sectors has often proven difficult. In some cases, policy makers have supported measures that are damaging to health, often drawing on overly narrow economic arguments that prioritise short-

term benefits to some sectors over long-term costs to society—for example, by promoting polluting extractive industries. Some policy makers have reservations that Health in All Policies means health ministers expect other people to solve their problems.

After two decades and an unprecedented public health crisis, it might be time to rethink these arguments. Everything affects health, but not everybody thinks health is their problem. Yet, maybe this point of view is changing as the COVID-19 pandemic has shown how a health threat can cause massive disruption and affect most aspects of life. We have also seen how countries can step up to the challenge, with different branches of government working together to create large-scale intersectoral responses to safeguard health, provided the threat is perceived as sufficiently great and the measures needed are agreed upon.⁹ Most countries have implemented measures to prevent disease transmission that were previously almost unimaginable, including reorienting health systems, controlling borders and internal mobility, redirecting the economy, and taking sometimes draconian civil protection measures.¹⁰ Heads of government have had no alternative but to work with their health ministers and other ministries and sectors, including social affairs, internal affairs, foreign affairs, and economic affairs.

Such collaboration among sectors in the name of health can and should continue. The challenge is to create win-win solutions that achieve multiple policy targets and to design policies that bring co-benefits for multiple sectors and support shared goals. Rather than discarding the Health in All Policies approach, we argue that it should be reinforced. Instead of just offering the unidirectional relationship implied by Health in All Policies (ie, health sector benefiting from other sectors), an expansion of thought is required to make this offer bidirectional (ie, both the health and other sectors benefiting from the relationship; figure 1). Through this concept, which we call Health for All Policies, health is put at the forefront, highlighting what the health sector can do for other sectors while simultaneously attaining co-benefits for its own sector.

Three reasons exist to focus on co-benefits as part of a Health for All Policies approach. First, as previous

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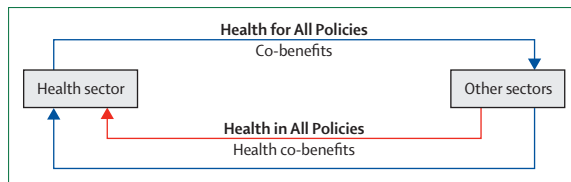


Figure 1: The association between health and other sectors

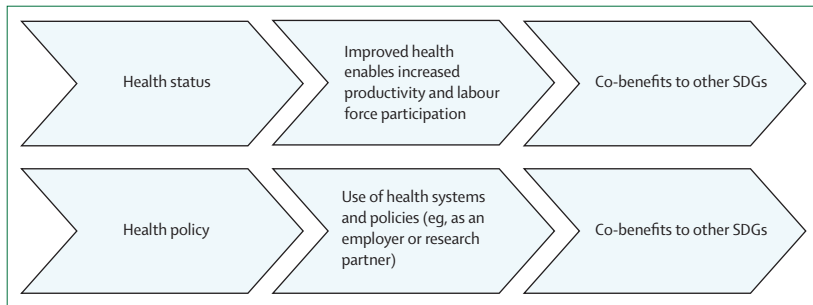


Figure 2: Causal pathways in Health for All Policies
SDGs=Sustainable Development Goals.

research has shown, simply inviting other sectors to pursue goals formulated by the health sector is not enough,^{11,12} and such a strategy should be complemented by an approach that emphasises the co-benefits of health policy for other sectors; investment can offer new opportunities on the basis of shared interests. Second, these co-benefits are likely to be necessary to attain key goals, as shown by the Sustainable Development Goals (SDGs); for example, health inequalities contribute to educational and employment inequalities,^{13,14} and catastrophic health-care costs can lead to impoverishment and business failure.¹⁵ Finally, the logic of co-benefits can offer ways for researchers and policy makers to understand interactions among factors leading to health inequalities. Researchers and policy makers can, for example, identify ways in which health policies and outcomes can contribute to improve economic growth through pathways such as increased involvement and productivity of the labour force, improved educational attainment, or enhanced biomedical research.^{16–18} Health for All Policies can create more resilient societies as we emerge from the COVID-19 pandemic.

The logic of health co-benefits

A co-benefit is simply a benefit from one policy (eg, better health through vaccinations) that contributes to the achievement of other policies. Two main routes can be pursued in parallel at different stages of the policy process. One is by looking at the effect of health outcomes—health status and health inequalities—on other policy goals. The other is by looking at the effect of health policies, such as employment conditions in the health sector or health initiatives in schools, on other goals (figure 2). The question for policy makers is: how do we understand, capture, and monitor co-benefits?

Co-benefits from improving health outcomes

The first category of co-benefits is the way in which improved health status and reduced health inequalities contribute to goals outside the health domain. Many examples exist, often associated with the SDGs. For instance, the health of children influences their educational performance (SDG 4, quality education), and health inequities influence the ability of women (SDG 5, gender equality), people living in poverty, and vulnerable groups (SDG 10, reduced inequalities) to receive the benefits of education and then secure equal access to good jobs (SDG 8, decent work and economic growth).

Empirical literature provides evidence on how health outcomes affect other policy goals.^{18–20} For example, Dillon and colleagues have shown that preventing malaria infection in Nigeria can increase earnings by about 10%.²¹ A separate study reported that severe health shocks in Denmark led to considerable increases in surviving spouses' labour supply.²² Existing literature can provide information on how health status affects other aspects of life and allow for estimation of the probable effect of a marginal improvement in health status on other goals.

Understanding and evidencing of the co-benefits of health outcomes should renew our focus on investing in health and perhaps lead us to rethink some priorities of the health sector.

Co-benefits from health policies

The second category of co-benefits arises when specific health policy interventions contribute to goals outside the health domain. For example, expanding universal health coverage or child nutrition programmes can reduce poverty by eliminating catastrophic health payments (SDG 1, no poverty). Limwattananon and colleagues²³ used a difference-in-difference analysis to show that a reform that greatly extended health insurance coverage in Thailand reduced out-of-pocket expenditure by 28% and reduced catastrophic health payments by 2 percentage points. Many empirical assessments of health policies have outcomes primarily focused on measuring their effectiveness within the health sector (health-care utilisation, health outcomes, and health-care costs), but this approach is overly restrictive. However, a wider perspective will require different expertise.

Conclusions

Health in All Policies was a starting point that is now ready to develop into Health for All Policies. In the aftermath of the COVID-19 pandemic, which revealed the fragility of many of our societies and reversed many gains of previous decades, we have learned that investing in the resilience of health systems is key for a country's economy and security.

A more practical, constructive, and evaluable approach is to focus on the co-benefits of policy and investment,

which would allow us to understand the contribution of health outcomes, policies, and systems to goals (such as the SDGs) that we, as a society, are trying to achieve.

Contributors

SLG, MF, and MW wrote the initial draft of the paper. SLG and MF designed the figures. MM and LS contributed to the editing. MM and JF reviewed the full draft of the paper and subsequent revisions.

Declaration of interests

We declare no competing interests.

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