Public policies **for the public's health**

Public policies in the health sector, together with those in other sectors, have a huge potential to secure the health of communities. They represent an important complement to universal coverage and service delivery reforms. Unfortunately, in most societies, this potential is largely untapped and failures to effectively engage other sectors are widespread. Looking ahead at the diverse range of challenges associated with the growing importance of ageing, urbanization and the social determinants of health, there is, without question, a need for a greater capacity to seize this potential. That is why a drive for better public policies – the theme of this chapter – forms a third pillar supporting the move towards PHC, along with universal coverage and primary care.

Chapter 4

The chapter reviews the policies that must be in place. These are:

- systems policies – the arrangements that are needed across health systems' building blocks to support universal coverage and effective service delivery;
- public-health policies – the specific actions needed to address priority health problems through cross-cutting prevention and health promotion; and
- policies in other sectors – contributions to health that can be made through intersectoral collaboration.

The chapter explains how these different public policies can be strengthened and aligned with the goals pursued by PHC.

The importance of effective public policies for health

People want to live in communities and environments which secure and promote their health[1]. Primary care, with universal access and social protection represent key responses to these expectations. People also expect their governments to put into place an array of public policies that span local through to supra-national level arrangements, without which primary care and universal coverage lose much of their impact and meaning. These include the policies required to make health systems function properly; to organize public-health actions of major benefit to all; and, beyond the health sector, the policies that can contribute to health and a sense of security, while ensuring that issues, such as urbanization, climate change, gender discrimination or social stratification are properly addressed.

A first group of critical public policies are the health systems policies (related to essential drugs, technology, quality control, human resources, accreditation, etc.) on which primary care and universal coverage reforms depend. Without functional supply and logistics systems, for example, a primary-care network cannot function properly: in Kenya, for example, children are now much better protected against malaria as a result of local services providing them with insecticide-treated bednets[2]. This has only been possible because the work of primary care was supported by a national initiative with strong political commitment, social marketing and national support for supply and logistics.

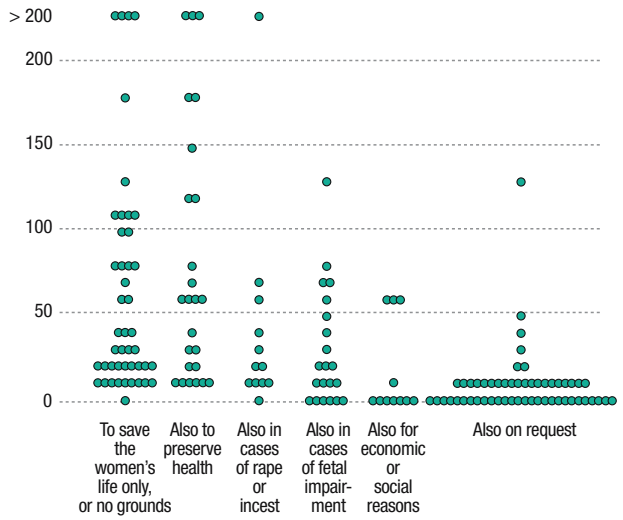
Effective public-health policies that address priority health problems are a second group without which primary care and universal coverage reforms would be hindered. These encompass the technical policies and programmes that provide guidance to primary-care teams on how to deal with priority health problems. They also encompass the classical public-health interventions, from public hygiene and disease prevention to health promotion. Some interventions, such as the fortification of salt with iodine, are only feasible at the regional, national or, increasingly at supra-national level. This may be because it is only at those levels that there is the necessary authority to decide upon such policies, or because it is more efficient to develop and implement such policies on a scale that is beyond the local dimensions of primary-care action. Finally, public policies encompass the rapid response capacity, in command-and-control mode, to deal with acute threats to the public's health, particularly epidemics and catastrophes. The latter is of the utmost political importance, because failures profoundly affect the public's trust in its health authorities. The lack of preparedness and uncoordinated responses of both the Canadian and the Chinese health systems to the outbreak of SARS in 2003, led to public outcries and eventually to the establishment of a national public health agency in Canada. In China, a similar lack of preparedness and transparency led to a crisis in confidence – a lesson learned in time for subsequent events[3,4].

The third set of policies that is of critical concern is known as "health in all policies", which is based on the recognition that population health can be improved through policies that are mainly controlled by sectors other than health[5]. The health content of school curricula, industry's policy towards gender equality, or the safety of food and consumer goods are all issues that can profoundly influence or even determine the health of entire communities, and that can cut across national boundaries. It is not possible to address such issues without intensive intersectoral collaboration that gives due weight to health in all policies.

Better public policies can make a difference in very different ways. They can mobilize the whole of society around health issues, as in Cuba (Box 4.1). They can provide a legal and social environment that is more or less favourable to health outcomes. The degree of legal access to abortion, for example, co-determines the frequency and related mortality of unsafe abortion[6]. In South Africa, a change in legislation increased women's access to a broad range of options for the prevention and treatment of unwanted pregnancy, resulting in a 91% drop in abortion-related deaths[7]. Public policies can anticipate future problems. In Bangladesh, for example, the death toll due to high intensity cyclones and flooding was 240 000 people in 1970. With emergency preparedness and multisectoral risk reduction programmes, the death toll of comparable or more severe storms was reduced to 138 000 people in 1991 and 4500 people in 2007[8,9,10].

In the 23 developing countries that comprise 80% of the global chronic disease burden, 8.5 million lives could be saved in a decade by a 15% dietary salt reduction through manufacturers voluntarily reducing salt content in processed foods and a sustained mass-media campaign encouraging dietary change. Implementation of four measures from the Framework Convention on Tobacco Control (increased tobacco taxes; smoke-free workplaces; convention-compliant packaging, labelling and awareness campaigns about health risks; and a comprehensive advertising, promotion, and sponsorship ban) could save a further 5.5 million lives in a decade[11]. As is often the case when considering social, economic and political determinants of ill-health, improvements are dependent on a fruitful collaboration between the health sector and a variety of other sectors.

Figure 4.1 Deaths attributable to unsafe abortion per 100 000 live births, by legal grounds for abortion[a,12,13]



[a]Every dot represents one country.

Box 4.1 Rallying society's resources for health in Cuba[14,15,16]

In Cuba, average life expectancy at birth is the second highest in the Americas: in 2006, it was 78 years, and only 7.1 per 1000 children died before the age of five. Educational indicators for young children are among the best in Latin America. Cuba has achieved these results despite significant economic difficulties – even today, GDP per capita is only I$ 4500. Cuba's success in ensuring child welfare reflects its commitment to national public-health action and intersectoral action.

The development of human resources for health has been a national priority. Cuba has a higher proportion of doctors in the population than any other country. Training for primary care gives specific attention to the social determinants of health. They work in multidisciplinary teams in comprehensive primary-care facilities, where they are accountable for the health of a geographically defined population providing both curative and preventive services. They work in close contact with their communities, social services and schools, reviewing the health of all children twice a year with the teachers. They also work with organizations such as the Federation of Cuban Women (FMC) and political structures. These contacts provide them with the means to act on the social determinants of health within their communities.

Cuban national policy has also prioritized investing in early child development. There are three non-compulsory preschool education programmes, which together are taken up by almost 100% of children under six years of age. In these programmes, screening for developmental disorders facilitates early intervention. Children who are identified with special needs, and their families, receive individual attention through multidisciplinary teams that contain both health and educational specialists. National policy in Cuba has not succumbed to a false choice between investing in the medical workforce and acting on the social determinants of health. Instead, it has promoted intersectoral cooperation to improve health through a strong preventive approach. In support of this policy, a large workforce has been trained to be competent in clinical care, working as an active part of the community it serves.

System policies that are aligned with PHC goals

There is growing awareness that when parts of the health system malfunction, or are misaligned, the overall performance suffers. Referred to variously as "core functions"[17] or "building blocks"[18], the components of health systems include infrastructure, human resources, information, technologies and financing – all with consequences for the provision of services. These components are not aligned naturally or simply with the intended direction of PHC reforms that promote primary care and universal coverage: to obtain that alignment requires deliberate and comprehensive policy arrangements.

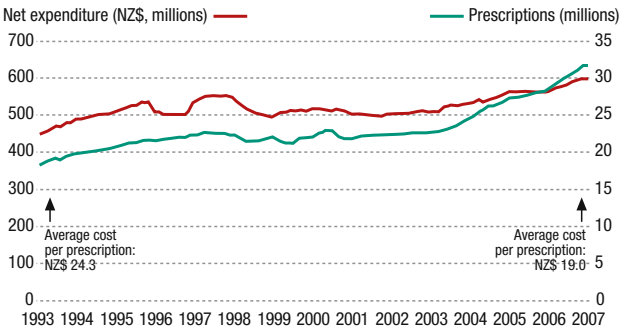
Experience in promoting essential medicines has shed light on both the opportunities and obstacles to effective systems policies for PHC. Since the *WHO List of Essential Medicines* was established in 1977, it has become a primary stimulus to the development of national medicines policies. Over 75% of the 193 WHO Member States now claim to have a national list of essential medicines, and over 100 countries have developed a national medicine policy. Surveys reveal that these policies have been effective in making lower cost and safer medicines available and more rationally used[19,20]. This particular policy has been successfully designed to support PHC, and it offers lessons on how to handle cross-cutting challenges of scale efficiencies and systems co-dependence. Without such arrangements, the health costs are enormous: nearly 30 000 children die every day from diseases that could easily have been treated if they had had access to essential medicines[21].

Medicines policies are indicative of how efficiencies in the scale of organization can be tapped. Safety, efficacy and quality of care have universal properties that make them amenable to globally agreed international standards. Adoption and adaptation of these global standards by national authorities is much more efficient than each country inventing its own standards. National decision-making and purchasing mechanisms can then guide rational, cost-effectiveness-based selection of medicines and reduce costs through bulk purchase. For example, Figure 4.2 shows how centralized oversight of drug purchasing and subsidization in New Zealand significantly improved access to essential medicines while lowering the average prescription price. On a larger scale, transnational mechanisms, such as UNICEF's international procurement of vaccines, PAHO's Revolving Fund and the Global Drug Facility for tuberculosis treatment, afford considerable savings as well as quality assurances that countries on their own would be unlikely to negotiate[22,23,24,25].

A second key lesson of experience with essential drugs policies is that a policy cannot exist as an island and expect to be effectively implemented. Its formulation must identify those other systems elements, be they financing, information, infrastructure or human resources, upon which its implementation is dependent. Procurement mechanisms for pharmaceuticals, for example, raise important considerations for systems financing policies: they are interdependent. Likewise, human resources issues related to the education of consumers as well as the training and working conditions of providers are likely to be key determinants of the rational use of drugs.

Systems policies for human resources have long been a neglected area and one of the main constraints to health systems development[27]. The realization that the health MDGs are contingent on bridging the massive health-worker shortfall in low-income countries has brought long overdue attention to a previously neglected area. Furthermore, the evidence of increasing dependence on migrant health workers to address shortages in OECD countries underlines the fact that one country's policies may have a significant impact on another's. The choices countries make – or fail to

Figure 4.2 Annual pharmaceutical spending and number of prescriptions dispensed in New Zealand since the Pharmaceutical Management Agency was convened in 1993[26]



make – can have major long-term consequences. Human resources for health are the indispensable input to effective implementation of primary care and universal coverage reforms, and they are also the personification of the values that define PHC. Yet, in the absence of a deliberate choice to guide the health workforce policy by the PHC goals, market forces within the health-care system will drive health workers towards greater sub-specialization in tertiary care institutions, if not towards migration to large cities or other countries. PHC-based policy choices, on the other hand, focus on making staff available for the extension of coverage to underserved areas and disadvantaged population groups, as with Malaysia's scaling up of 11 priority cadres of workers, Ethiopia's training of 30 000 Health Extension Workers, Zambia's incentives to health workers to serve in rural areas, the 80 000 Lady Health Workers in Pakistan, or the task shifting for the care of HIV patients. These policies direct investments towards the establishment of the primary-care teams that are to be the hub of the PHC-based health system: the 80 000 health workers for Brazil's 30 000 Family Health Teams or the retraining of over 10 000 nurses and physicians in Turkey. Furthermore, these policies require both financial and non-financial incentives to compete effectively for scarce human resources, as in the United Kingdom, where measures have been taken to make a career in primary care financially competitive with specialization.

The core business of ministries of health and other public authorities is to put into place, across the various building blocks of the health system, the set of arrangements and mechanisms required to meet their health goals. When a country chooses to base its health systems on PHC – when it starts putting into place primary care and universal coverage reforms – its whole arsenal of system policies needs to be aligned behind these reforms: not just those pertaining to service delivery models or financing. It is possible to develop system policies that do not take account of the PHC agenda. It is also possible to choose to align them to PHC. If a country opts for PHC, effective implementation allows no half measures; no health systems building block will be left untouched.

Public-health policies

Aligning priority health programmes with PHC

Much action in the health sector is marshalled around specific high-burden diseases, such as HIV/AIDS, or stages of the life course such as children – so-called priority health conditions. The health programmes that are designed around these priorities are often comprehensive insofar as they set norms, ensure visibility and quality assurance, and entail a full range of entry points to address them locally or at the level of countries or regions. Responses to these priority health conditions can be developed in ways that either strengthen or undercut PHC[28].

In 1999 for example, the Primary Care Department of the Brazilian Paediatrics Society (SBP) prepared a plan to train its members in the Integrated Management of Childhood Illness (IMCI) and to adapt this strategy to regional epidemiological characteristics[29]. Despite conducting an initial training course, the SBP then warned paediatricians that IMCI was not a substitute for traditional paediatric care and risked breaching the basic rights of children and adolescents. In a next step, it objected to the delegation of tasks to the nurses, who are part of the multidisciplinary family health teams, the backbone of Brazil's PHC policy. Eventually, the SBP attempted to reclaim child and adolescent care as the exclusive domain of paediatricians with the argument that this ensured the best quality of care.

Experience with priority health programmes shows that the way they are designed makes the difference: trying to construct an entire set of PHC reforms around the unique requirements of a single disease leads to considerable inefficiencies. Yet, the reverse is equally true. While AIDS has been referred to as a metaphor for all that ails health systems and the wider society[30], the global response to the HIV pandemic can, in many respects, also be viewed as a pathfinder for PHC. From the start, it has had a strong rights-based and social justice foundation[31]. Its links to often marginalized and disadvantaged high-risk constituencies, and concerns about stigma, have led to concerted efforts to secure their rights and entitlements to employment, social services and

health care. Efforts to scale-up services to conform to the goals of universal access have helped to expose the critical constraints deriving from the workforce crisis. The challenge of providing life-long treatment in resource-constrained settings has inspired innovations, such as more effective deployment of scarce human resources via "task shifting", the use of "patient advocates"[32], and the unexpected implementation of electronic health records. Most importantly, the adoption of a continuum of care approaches for HIV/AIDS from prevention to treatment to palliation has helped to revive and reinforce core features of primary care, such as comprehensiveness, continuity and person-centredness[32].

Countrywide public-health initiatives

While it is essential that primary-care teams seek to improve the health of populations at local level, this may be of limited value if national- and global-level policy-makers fail to take initiatives for broader, public policy measures, which are important in changing nutrition patterns and influencing the social determinants of health. These can rarely be implemented only in the context of local policies. Classical areas in which beyond-local-scale public-health interventions may be beneficial include: altering individual behaviours and lifestyles; controlling and preventing disease; tackling hygiene and the broader determinants of health; and secondary prevention, including screening for disease[33]. This includes measures such as the fortification of bread with folate, taxation of alcohol and tobacco, and ensuring the safety of food, consumer goods and toxic substances. Such national- and transnational-scale public-health interventions have the potential to save millions of lives. The successful removal of the major risk factors of disease, which is technically possible, would reduce premature deaths by an estimated 47% and increase global healthy life expectancy by an estimated 9.3 years[34]. However, as is the case for the priority programmes discussed above, the corresponding public-health policies must be designed so as to reinforce the PHC reforms.

Not all such public-health interventions will improve, for example, equity. Health promotion efforts that target individual risk behaviours, such as health education campaigns aimed at smoking, poor nutrition and sedentary lifestyles, have often inadvertently exacerbated inequities. Socioeconomic differences in the uptake of one-size-fits-all public-health interventions have, at times, not only resulted in increased health inequities, but also in victim-blaming to explain the phenomenon[35]. Well-designed public-health policies can, however, reduce inequities when they provide health benefits to entire populations or when they explicitly prioritize groups with poor health[36]. The evidence base for privileging public policies that reduce inequities is increasing, most notably through the work of the Commission on Social Determinants of Health (Box 4.2)[37].

Rapid response capacity

While PHC reforms emphasize the importance of participatory and deliberative engagement of diverse stakeholders, humanitarian disasters or disease outbreaks demand a rapid response capacity that is crucial in dealing effectively with the problem at hand and is an absolute imperative in maintaining the trust of the population in their health system. Invoking quarantines or travel bans, rapidly sequencing the genome of a new pathogen to inform vaccine or therapeutic design, and mobilizing health workers and institutions without delay can be vital. While the advent of an "emergency" often provides the necessary good will and flexibility of these diverse actors to respond, an effective response is more likely if there have been significant investments in preparedness[38].

Global efforts related to the threat of pandemic avian influenza (H5N1) provide a number of interesting insights into how policies that inform preparedness and response could be guided by the values of PHC related to equity, universal coverage and primary-care reforms. In dealing with seasonal and pandemic influenza, 116 national influenza laboratories, and five international collaborating centre laboratories share influenza viruses in a system that was started by WHO over 50 years ago. The system was implemented to identify new pandemic virus threats and inform the optimal annual preparation of a seasonal influenza vaccine that is used primarily by industrialized countries. With the primarily

Box 4.2 Recommendations of the Commission on Social Determinants of Health[37]

The Commission on Social Determinants of Health (CSDH) was a three-year effort begun in 2005 to provide evidence-based recommendations for action on social determinants to reduce health inequities. The Commission accumulated an unprecedented collection of material to guide this process, drawing from theme-based knowledge networks, civil society experiences, country partners and departments within WHO. The final report of the CSDH contains a detailed series of recommendations for action, organized around the following three overarching recommendations.

1. Improve daily living conditions

Key improvements required in the well-being of girls and women; the circumstances in which their children are born, early child development and education for girls and boys; living and working conditions; social protection policy; and conditions for a flourishing older life.

2. Tackle the inequitable distribution of power, money and resources

To address health inequities it is necessary to address inequities in the way society is organized. This requires a strong public sector that is committed, capable and adequately financed. This in turn requires strengthened governance including stronger civil society and an accountable private sector. Governance dedicated to pursuing equity is required at all levels.

3. Measure and understand the problem and assess the impact of action

It is essential to acknowledge the problem of health inequity and ensure that it is measured – both within countries and globally. National and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health are required that also evaluate the health equity impact of policy and action. Other requirements are the training of policy-makers and health practitioners, increased public understanding of social determinants of health, and a stronger social determinants focus in research.

developing country focus of human zoonotic infections and the spectre of a global pandemic associated with H5N1 strains of influenza, the interest in influenza now extends to developing countries, and the long-standing public-private approach to influenza vaccine production and virus sharing has come under intense scrutiny. The expectation of developing countries for equitable access to protection, including affordable access to anti-virals and vaccines in the event of a pandemic, is resulting in changes to national and global capacity strengthening: from surveillance and laboratories to capacity transfer for vaccine formulation and production, and capacity for stock-piling. Thus, the most equitable response is the most effective response, and the most effective rapid response capacity can only emerge from the engagement of multiple stakeholders in this global process of negotiation.

Towards health in all policies

The health of populations is not merely a product of health sector activities – be they primary-care action or countrywide public-health action. It is to a large extent determined by societal and economic factors, and hence by policies and actions that are not within the remit of the health sector. Changes in the workplace, for example, can have a range of consequences for health (Table 4.1).

Confronted with these phenomena, the health authorities may perceive the sector as powerless to do more than try to mitigate the consequences. It cannot, of itself, redefine labour relations or unemployment arrangements. Neither can it increase taxes on alcohol, impose technical norms on motor vehicles or regulate rural migration and the development of slums – although all these measures can yield health benefits. Good urban governance, for example, can lead to 75 years or more of life expectancy, against as few as 35 years with poor governance[39]. Thus, it is important for the health sector to engage with other sectors, not just in order to obtain collaboration on tackling pre-identified priority health problems, as is the case for well-designed public-health interventions, but to ensure that health is recognized as one of the socially valued outcomes of all policies.

Such intersectoral action was a fundamental principle of the Alma-Ata Declaration. However, ministries of health in many countries have struggled to coordinate with other sectors or wield influence beyond the health system for which they are formally responsible. A major obstacle to reaping the rewards of intersectoral action has been the tendency, within the health sector, to see such collaboration as "mostly symbolic in trying to get other sectors to help [health] services"[40]. Intersectoral action has often not concentrated

Table 4.1 Adverse health effects of changing work circumstances[5]

Adverse health effects of unemployment	Adverse health effects of restructuring	Adverse health effects of non-standard work arrangements
Elevated blood pressure	Reduced job satisfaction, reduced organizational commitment and greater stress	Higher rates of occupational injury and disease than workers with full-time stable employment
Increased depression and anxiety	Feelings of unfairness in downsizing process	High level of stress, low job satisfaction and other negative health and well-being factors
Increased visits to general practitioners	Survivors face new technologies, work processes, new physical and psychological exposures (reduced autonomy, increased work intensity, changes in the characteristics of social relationships, shifts in the employment contracts and changes in personal behaviour)	More common in distributive and personal service sub-sectors where people in general have lower educational attainment and low skill levels
Increased symptoms of coronary disease	Changes in the psychological contract and lost sense of trust	Low entitlement to workers' compensation and low level of claims by those who are covered
Worse mental health and greater stress	Prolonged stress with physiological and psychological signs	Increased occupational health hazards due to work intensification motivated by economic pressures
Increased psychological morbidity and increased medical visits		Inadequate training and poor communication caused by institutional disorganization and inadequate regulatory control
Decreased self-reported health status and an increase in the number of health problems		Inability of workers to organize their own protection
Increase in family problems, particularly financial hardships		Cumulative trauma claims are difficult to show due to mobility of workers
		Reduced ability to improve life conditions due to inability to obtain credit, find housing, make pension arrangements, and possibility for training
		Fewer concerns for environmental issues and health and safety at work

on improving the policies of other sectors, but on instrumentalizing their resources: mobilizing teachers to contribute to the distribution of bednets, police officers to trace tuberculosis treatment defaulters, or using the transport of the department of agriculture for the emergency evacuation of sick patients.

A "whole-of-government approach", aiming for "health in all policies" follows a different logic[41,42]. It does not start from a specific health problem and look at how other sectors can contribute to solving them – as would be the case, for example, for tobacco-related disease. It starts by looking at the effects of agricultural, educational, environmental, fiscal, housing, transport and other policies on health. It then seeks to work with these other sectors to ensure that, while contributing to well-being and wealth, these policies also contribute to health[5].

Other sector's public policies, as well as private sector policies, can be important to health in two ways.

- Some may lead to adverse consequences for health (Table 4.1). Often such adverse consequences are identified retrospectively, as in the case of the negative health effects of air pollution or industrial contamination. Yet, it is also often possible to foresee them or detect them at an early stage. Decision-makers in other sectors may be unaware of the consequences