HEALTH IS ON THE POLITICAL AGENDA

One of the key goals for health promotion has been ‘to move health high on the political agenda’. This was stated clearly in the Adelaide recommendations of 1988 (WHO, 1988) and has been a key goal of health advocacy ever since. Today health has moved up the political agenda to an extent one could not have envisaged even 10 years ago—for example, it was a defining factor in the US elections 2008 and of the first year of the Obama presidency. Why is this?

Health has become vital to overall government performance at the national level and a key factor in voting behaviours in democracies and of government legitimacy in autocratic states. The reasons are manifold for example: the control of health care costs is now considered as a key tenant for broader economic stability and growth of societies as well as a component of competitiveness of national economies; the overall costs to society of certain health conditions are increasingly discussed and include concerns about the effect of population ageing on both the economy and productivity.

Health is also ever more present in the international arena, not only in the discussions at the World Health Assembly, but also at the United Nations, at the G8 and the G20, and at other international organizations such as the World Trade Organization, the OECD and the World Bank. At the global level health intersects with security as well as trade and intellectual property issues, health has become a core factor of development strategies such as the Millennium Development Goals. It is linked to foreign policy and the geo-political and economic interests of countries. The growth of the health care industry and the increasing mobility of patients and health professionals constitute a new dimension in the global arena. Finally health intersects with many other agendas such as climate change and food security.

Health is increasingly visible in the public and political debate in many ways for example: cuts in health care provision, rising insurance premiums, vaccination in relation to global pandemics, the regulation of products such as tobacco, alcohol or fast food, the price of medicines or the issue of major health inequalities. All these relate to larger agendas such as the freedom of markets, the responsibility of individuals, the protection of vulnerable groups and the extent of state intervention. This makes any health issue inherently political and in many cases transports it into the realm of ideology as is evident in the conflict between health interests and market forces. In summary one could say that health is in the process of moving from being a vertical and sectoral issue to one that relates significantly to larger societal goals and in consequence gets mired in the conflicts that emerge in the definition of such goals.

HEALTH NEEDS SHARED GOVERNANCE

The statement ‘Inequality kills’ is clearly of a different nature than the statement ‘disease kills’ and leads to a completely different set of policy priorities and key actors. A societal goal such as ‘equity’ would have health as one important indicator; both the health sector and other sectors would be accountable for their respective contribution towards such a goal. This is critical for twenty-first century health policy because good or bad health outcomes depend on the action of other sectors but also affect the outcomes of a wide range of other sectors. The 2010 Adelaide Statement on Health in All Policies (WHO, Government of South Australia, 2010) advocates such a view
based on the experiences gained by the South Australian government in applying their health lens approach. In South Australia health has not only become part of the overall strategic plan of the state—the SASP—but is now identified as a key component of the strategic revisions underway. A new mindset of shared governance for health has been adopted.

The Adelaide statement is a strong plea for shared governance for health and well-being—it reflects not only on how other sectors contribute to health but how health can contribute to the goals of other sectors. It aims to address the complex dynamics of the determinants of health, all of which are an expression of the interdependent ‘wicked problems’ twenty-first century societies face. This multi-dimensional nature of health needs an integrated and dynamic policy response across portfolio boundaries—something that is most difficult to achieve in organizations that are (in political science terms) ‘organized anarchies’, that is to say organizations with shifting actors, problematic preferences and trial and error decision-making (Cohen et al., 1972). In most governments the incentives continue to be aligned with outputs for individual departments rather than for outputs shared across agencies and departments.

The health sector is a particularly vertical configuration with a concentration of specialist medical knowledge and very well-organized professional special interests. It is not well equipped (and often not willing) to deal with many of the contemporary public health challenges which are all intersectoral in nature and often also require partnerships outside of government. It is also not well prepared for being in the centre of the political storms that ensue.

A similar point could be made in relation to the World Health Organization. It is challenged to find new ways to work with other sectors, to take into account the impact of health on other sectors (for example, in relation to the International Health Regulations) and to bring the health perspective into the political negotiations in other major policy arenas. One expression of this need for intersectorality is the increasing tendency to take health issues to the General Assembly of the United Nations, albeit in close cooperation with the WHO. For example for the first time ever, the United Nations General Assembly will hold a Non-communicable Disease (NCD) Summit involving Heads of State, in September 2011, to address the threat posed by NCDs to low- and middle-income countries (LMICs). This follows on UN discussions of HIV AIDS, of health related Millennium Development Goals and of global health and foreign policy.

Yet we are far from having a ‘health in all policies’ governance system in place. I have stated elsewhere that this presents an historic effort akin to the creation of the public health systems in the late 19th and the medical care system in the early 20th century (Kickbusch, 2010). Although we advocate for health in all policies we lack strategies on how to overcome the sector-based approach to governance, and we are faced with trade offs regarding systemic approaches (such as around health systems or food systems) and vertical approaches (such as around individual diseases, be they infectious or chronic). The Adelaide Statement outlines when Health in All Policies work best and what tools and instruments can be useful at different stages of the policy cycle. Illustrations are provided in the book prepared for the conference (Kickbusch and Buckett, 2010) and the issue of the SA Health Public Health Bulletin (SA Health Public Health Bulletin, 2010) published following the conference. Analytical Guidance is also provided by the Framework of conditions for intersectoral health governance developed in Canada (St. Pierre and Gauvin, 2010).

**PREPARING FOR HELSINKI 2013**

We now have a way to take our thinking further based on the experiences in countries, regions and localities. A unique opportunity will be provided by the 2013 Global Conference on Health Promotion in Helsinki Finland. I would like to suggest that the 3 years leading up to the 2013 conference be used for in depth studies on shared governance for health—within government and at various levels and between government and other societal actors. Actions should comprise the following:

(i) First, we need to provide a clear 25 year analysis—including a more far reaching historical review—of the ways in which health is reflected in the political agenda at the beginning of the twenty-first century—and what changes have occurred in the recent past.
(ii) Second, we must look in depth at a number of defined critical issues such as equity, food, ageing, security, trade and climate change, the shared governance approaches they need and the role health needs to play. A country, group of countries or a WHO Regional Office could each take the responsibility for preparing one issue in depth for the conference. Ideally this could be a combined effort with representatives from other sectors and disciplines.

(iii) Third, we need background papers focussing on the ‘how’ of shared governance—to understand better governance systems, infrastructures, tools, instruments and processes. We also need to identify the critical capacities for shared governance for health and well-being.

These papers would provide the knowledge base and intellectual capital of the conference and would be debated at the conference in real time and virtually—and this is critical—together with the representatives from other sectors and from key strategic government departments, such as the Office of the Prime Minister. We need to have this debate on shared governance together. We also need to involve other disciplines—in particular political science—in this venture.

The joined theoretical base could be John Kingdon’s seminal work laid out in ‘Agendas, Alternatives and Public Policies’—which shows that policy is the result of the convergence of three independent streams—problems, policy alternatives and politics (Kingdon, 1995). Policy agendas and outcomes are usually not the result of a rationale assessment of all possible policy options but action triggered by windows of opportunity which can be opened by policy entrepreneurs. Key considerations are:

Problems: Kingdon shows how an issue is transformed from a condition to a problem. A condition is something that cannot or need not be changed. A problem is something that policy makers must address. For example if health care is regarded as a right, Kingdon observes, it is a problem that needs to be dealt with—if health care is not regarded as a right, then it is a condition which policy makers can neglect. We can analyse in which areas we have been successful in setting new health policy agendas by turning conditions into ‘problems’—and what unintended consequences possibly might have emerged. For example in health it seems easier to address vertical disease-based problems with medical solutions rather than systemic issues and approaches. What has this meant for health promotion in general and for Health in All Policies in particular?

Alternatives: We can further document the many policy alternatives in relation to the promotion of health that have emerged in the last two decades at various levels of governance. Kingdon asserts that policy alternatives are more likely to survive if they are well cooked. This means that a new proposal is more likely to be the result of recombining well-understood existing ideas than a completely new approach—and its acceptance implies a tactic of constant persuasion. Authors maintain that it is in this area that academics can contribute most to the policy process. A good example is the report of the Commission on Social Determinants of Health (WHO, 2008) which recombined much of the health promotion thinking with a stronger equity focus in a new language. We must keep this in mind as we get impatient and constantly try to reinvent health promotion rather than stick to our key messages. Innovation cycles can take up to thirty years. I believe we are now in a good position—25 years after the Ottawa Charter—to document technically feasible policy proposals. One such example is the recent publication by the WHO of robust experiences in implementing 13 public health programs—including alcohol and tobacco reduction, mental health, injuries and violence prevention, neglected tropical diseases, and many others—using intersectoral mechanisms in a variety of settings (WHO, 2010).

Politics: Finally the stream that is probably the most difficult is the political. I suggest that the preparatory work for the Helsinki Conference pay more attention to the political determinants of health than we have done so far. We need to understand better the political factors that led to success or failure of health promotion in general and of Health in All Policies in particular. This is not because they will repeat themselves in exactly the same manner, but in order to recognize their characteristics and to be able to use windows of opportunity as they open. Politics in democracies is all about bargaining and compromise—the health in all policies process is basically a process of health diplomacy, negotiating for a health interest in an environment of ‘organized anarchy’. We need to understand the political process better and not assume—as so many of our models do—that it is a rational process, a viewpoint that is reflected in (from a political science perspective) unrealistic terms such as ‘evidence based policy’. As a leading expert in international relations (Krasner, 2009) says ‘The conditions for fully rational decision making almost never hold’. At best we can hope for evidence-informed policies.

In my view such systematic preparatory work could move shared governance for health
forward significantly. Examples from different political systems and cultures would increase the validity of the approach. Involving people from other sectors and disciplines in the preparatory work would make it more probable that they would also attend the event itself. The conference would then become a historical watershed for public health and health promotion and move health governance into the twenty-first century.

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REFERENCES


