of data, including the accompanying rules for protecting patient privacy. In the quest to focus on outcomes, and to pay for results, private and public players need to find ways to automatically capture data and keep track of the agreements they have made. Furthermore, the life sciences and health care sectors should be vigilant about cybersecurity threats which will likely increase in future.

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INCLUSIVE GROWTH AS A ROUTE TO TACKLING HEALTH INEQUALITIES

By: Emma Spencelayh

Summary: There are entrenched health inequalities between and within countries that continue to be unacceptable, in part because inequalities represent a failure of government to maximise the social and economic potential of its population. The Sustainable Development Goals provide a framework for cross-sector action and the translation of benefits from one sector to another. There are great opportunities for health policy makers and practitioners to tap into economic development agendas such as inclusive growth as a route to tackling health inequalities.

Keywords: Inclusive Growth, Health Inequalities, Social Determinants, Sustainable Development Goals

Revisiting the Declaration of Alma-Ata declaration

Thirty years ago, the declaration of Alma-Ata made it clear that the level of health inequality was ‘politically, socially, and economically unacceptable’. Three decades on, we are still facing the issue of entrenched health inequalities between and within countries. For example, across countries, life expectancy varies by 34 years – a child born in Sierra Leone can expect to live for 50 years while a child born in Japan can expect to live for 84 years. As an example of in-country inequalities, across the United Kingdom from 2014 to 2016, the gap in healthy life expectancy at birth between local areas with highest and lowest average health life expectancy was 18.4 years for females and 15.6 years for males.

While there are clear and sound arguments for investing in health care systems as a route to improved health outcomes, tackling unacceptable variations cannot be left to the health care system alone, which is only one of many factors contributing to overall health outcomes. A wide variety of factors contribute to a person’s health and wellbeing, including access to education and good work, environmental factors such as decent homes and pleasant surroundings and strong social networks. These influences (the social determinants of health) are not distributed equally and are strongly shaped by government policy, including economic, social, housing and planning policies.

It can be difficult to determine the precise role the social determinants have compared to health care delivery or

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other factors. Recent research using data from more than 1.7 million individuals in 48 independent cohort studies in seven countries found that the independent association between socio-economic status and mortality is comparable in strength and consistency to the individual effects of other more widely recognised risk factors such as tobacco use, alcohol consumption, insufficient physical activity, raised blood pressure, obesity or diabetes.

Can the Sustainable Development Goals (SDGs) play a role in bridging sectors?

The United Nation’s SDGs provide a framework and a call to action for ending poverty, protecting the planet and enabling people to enjoy peace and prosperity. The SDG framework provides an excellent opportunity to position a health in all policies approach within a broader comprehensive, inter-sectoral approach to national policymaking. It also provides the opportunity to show that good health has a role to play in supporting sustainable development more broadly. The Adelaide Statement II on health in all policies 2017 highlights the opportunities the SDGs provide to reach out across different sectors, while emphasising that health in all policies can be a vehicle to support SDG implementation, particularly in relation to improvements around policy coherence.

The health of a population has a complex, multi-directional relationship with other social and economic outcomes. Good health is of course of value to individuals but it is also a societal asset that can help enable people and places to flourish. Evidence suggests that progress on target 3.4 (reducing preventable mortality by a third by 2030) would have a role in determining the outcome of at least nine SDGs. For example, reducing the mortality and morbidity from non-communicable diseases could lead to a rise in productivity and household incomes, helping to achieve progress against Goal 8 (decent work and economic growth) and Goal 10 (reduced inequalities). In turn, the SDGs provide an opportunity to make progress in the areas that are likely to affect people’s life trajectories and experiences such as the environment in which they live and the sorts of jobs available which should in turn support good health.

The SDG framework doesn’t offer a perfect blueprint for tackling health inequalities – for example, the health targets are absolute rather than relative and there is no mention of health inequalities within the overall set of indicators on inequality. However, the focus on policy coordination and policy coherence, as well as partnership working, highlights the need for activity that is mutually enhancing across sectors. In particular, there is a great opportunity to tap into work to promote more inclusive, economic growth.

Inclusive growth as a means to tackling health inequalities

Goal 8 promotes inclusive and sustainable economic growth, employment and decent work for all. There is a growing recognition that the proceeds of economic growth should be shared more equally across the population. Widening income inequality has been referenced as the defining challenge of our time and can be evidence of a lack of opportunity and risks concentrating power in the hands of the few, which can threaten economic stability and social cohesion.

Gross Domestic Product statistics are the main way in which economic performance is measured and reported on at a national level. This focuses attention on policies that aim to affect the overall level of economic activity in areas such as skills development, labour markets, competition, investor and corporate governance, social protection, infrastructure basic services, which in turn shape patterns of who benefits from growth.

Inclusive growth (see Box 1) is a term that originally gained prominence within the international development field by groups such as the World Bank. Though this term was originally used to discuss economic development in lower-middle income countries, it has quickly been adopted in higher-income countries too.

Why does this matter for health outcomes?

Income inequality is important from a health perspective as it is widely accepted that there is a social gradient in health.
Box 1: Inclusive growth

There are multiple definitions of inclusive growth but there are several key ideas that are consistent, such as ‘ensuring opportunities for all’ and ‘broad-based growth’.

The OECD defines inclusive growth as “economic growth that creates opportunity for all segments of the population and distributes the dividends of increased prosperity, both in monetary and non-monetary terms, fairly across society”.

The European Commission states that inclusive growth involves: “empowering people through high levels of employment, investing in skills, fighting poverty and modernising labour markets, training and social protection systems so as to help people anticipate and manage change, and build a cohesive society... It is about ensuring access and opportunities for all... making full use of [Europe’s] labour potential.”

The association between socio-economic status and health status is well established. For example, the European Commission’s recent report on fairness notes that individuals with a poor family background are more likely to smoke or be overweight or obese than those from more privileged family background. The chance of reporting poor health for those from a poor family background are nearly 110% higher (after accounting for age and gender).

The OECD has outlined that health is a critical component of inclusive growth, both as a major dimension of wellbeing in itself and because of its two-way relationship with income, employment and other key aspects of living standards.

Tapping into the inclusive growth agenda has the potential to facilitate mutually beneficial action across economic development and health sectors. For example, the OECD’s framework for policy action on inclusive growth focuses on action to:

- Invest in people and places that have been left behind, providing equal opportunities for all
- Support business dynamism and inclusive labour markets
- Build efficient and responsive governments

These areas of focus are well aligned with policy recommendations to address health inequalities arising from social and economic determinants. The World Health Organization’s (WHO) Commission on the Social Determinants of Health’s overarching recommendations highlighted the need to improve daily living conditions and tackle the inequitable distribution of power, money and resources.

The World Economic Forum’s (WEF) virtuous cycle of inclusive growth shows a self-reinforcing cycle in which rising economic output and social inclusion support each other. The WEF also argues that there is no inherent trade-off in economic policymaking between the promotion of social inclusion and that of long-term economic growth and competitiveness.

While it may be tempting to view inclusive growth as a silver bullet, it is also important to recognise its limitations. Growth may not be a sustainable goal in itself – either at a national or subnational level. In some areas, inclusive economics may need to facilitate policies that actively support the redistribution of resources within a neutral or ‘degrowth’ context.

Conclusions

A healthy population is essential for a thriving society and economy. The SDGs provide an opportunity and catalyst for health to bridge barriers with sectors such as economic development and to advance mutually beneficial policies. The inclusive growth agenda is creating a focus on inequalities in the broadest sense and it is important that action to tackle health inequalities isn’t attempted in isolation when there are clear opportunities for alignment and amplification of action. Whole system approaches are difficult to deliver in practice but the SDGs, with their emphasis on whole government action, provide new and much needed impetus for innovative approaches to policymaking.

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Using economic evidence to help make the case for investing in health promotion and disease prevention

By: David McDaid

Copenhagen: World Health Organization 2018 (acting as the host organisation for, and secretariat of, the European Observatory on Health Systems and Policies)

Freely available to download at: http://www.euro.who.int/_data/assets/pdf_file/0003/380730/pb-tallinn-02-eng.pdf?ua=1

The 2008 Tallinn Charter: Health Systems for Health and Wealth recognised that investing in health means investing in human development, social well-being and wealth. It stated that “health systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies”.

Ten years on, investment in health promotion and disease prevention activities, at least within the health sector, remains stubbornly low in many countries. For instance, OECD countries typically allocate between 2% and 4% of total health sector spending to these activities. Moreover, between 2009/2010 and 2012/2013 on average spending fell in real terms and still in 2014/2015 was only growing at around 2% per annum, a rate that is much lower than before the onset of the global economic crisis.

There are many different reasons for this, but undoubtedly some budget holders in health systems are sceptical about the case for focusing more on public health, contending that there is insufficient evidence available to justify such an investment.

This policy brief argues that this scepticism about the evidence is overstated. Moreover, the existing evidence base can in fact be adapted to be useful in many different systems and country contexts across the WHO European Region.