Hooked on Health Care: Designing Strategies for Better Health

Pre-session Briefing

EMMA SPENCELAYH, SENIOR POLICY ADVISER, THE HEALTH FOUNDATION

JO BIBBY, DIRECTOR OF STRATEGY AND INNOVATION, THE HEALTH FOUNDATION

Background to *Hooked on Health Care: Designing Strategies for Better Health*

The Health Foundation and the Robert Wood Johnson Foundation are pleased to be joining in support of this Salzburg Global Seminar session on designing strategies for *better health.* Both foundations work in a context where the burden of disease and demand for health care services continue to grow. And yet, while the case for prevention in both their home countries is strong, as it is elsewhere, the focus of health strategies still largely remain in the provision of health care services rather than through addressing the wider determinants of health. These challenges are not unique to high income countries, such as the United Kingdom or the United States – they are of pressing concern worldwide.

Faced with these challenges, the foundations want to explore with other countries how they are prioritizing actions to maintain and improve health rather than simply see treatment of ill health as an inevitable cost to governments and citizens. This subject matter is not new – indeed the case has been made many times before for the importance of a "health in all policies" approach. However, while the overall objective might be clear, implementation is far more challenging.

This paper seeks to establish a shared starting point for discussion. The literature referenced is intended to be illustrative rather than comprehensive. While each of the countries represented at the Salzburg Global session will have different starting points, institutional structures and levels of development, this offers a stimulus to explore the learning and challenges that are common and relevant across participants regardless of the context within which they are operating.

How do people define health?

There is a breadth of understanding and definition of the term "health." One such example is the adoption of a positive approach, where health is viewed as a capacity or an asset versus a negative approach, which emphasizes the absence of specific illnesses, diseases or disorders.[1] Broadly speaking, the negative and positive constructs of health fit with a medical model and a social model as described in **Table A**. [2]

Table A: A comparison between the medical and social models of health taken from Warwick-Booth, L et al (2012). [3]	
Medical model	**Social model**
Narrow or simplistic understanding of health	Broad or complex understanding of health
Medically biased definitions focusing on the absence of disease or disability	More holistic definitions of health taking a wider range of factors into account such as mental and social dimensions of health
Doesn't take into account the wider influences on health (outside of the body)	Takes into account wider influences on health such as the environment and the impact of inequalities
Influenced by scientific and expert knowledge	Takes into account lay knowledge and understanding
Emphasizes personal, individual responsibility for health	Emphasizes collective, social responsibility for health

The concept of salutogenesis as advocated by Antonovsky is clearly rooted in the positive approach to defining health. Antonovsky proposed a continuum model of health where each of us is on a continuum between well or diseased with "*salutogenesis*" describing an approach that focuses on the factors that help to understand the movement of people in the direction of health. It is possible to see links between salutogenesis and the social, positive approach taken towards health promotion at the first international conference on health promotion in Ottowa in 1986 conference where heath was defined as *"a positive concept emphasizing social and personal resources, as well as physical capacities…Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love…"*[4]

While defining health can be challenging and open to multiple theories, perspectives and experiences, the World Health Organization's definition, combining both social and medical models is perhaps the most well-known. The definition covers an extremely broad spectrum of issues by suggesting that *"health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity."*[5] While the definition sends an important signal that health encompasses many facets, there has been criticism of the scale and complexity of the definition[6] and questions about whether the definition is still fit for purpose given the rise of chronic disease[7] and indeed whether any of us are truly absent of disease given the advances in genetic testing and medical advances[8].

Further, it has been suggested that the definition of health should be framed around the services that society can afford[9] with the current definition lending itself more to happiness than to health, making it unobtainable as the quest for happiness is individual and without boundaries.[10] In addition, there is always a degree of subjectivity in any individual or group defining their own health because of the diverse trade-offs implied in doing so.

These criticisms pose important questions. Does attempting to tackle the wider determinants of health (and potentially happiness) in their totality make the task too big and too daunting? Or does it challenge us to address those issues most likely to have greatest societal impact? How can we encourage people to consider the longer-term impact of their behavior on their long-term health status? And how can we encourage investment in health when the impact might not be immediate?

Both the Robert Wood Johnson Foundation and the Health Foundation as the sponsors of this Salzburg Global session, which is part of Salzburg Global's long-running *Health and Health Care Innovation* series, have done work to improve health care and are moving now into looking at how they can contribute to improving health. While the journey towards health and not health care will be difficult and slow, it is an initiative that is too important to fail.

Why does health matter?

The World Health Organization in 1946 outlined that the "*enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being…*"[11] – a principle that was later supported in the 1948 Universal Declaration of Human Rights which outlines that people have a right to a standard of living adequate for the health and wellbeing of themselves and their families[12]. While health can be seen as a fundamental right, it has been suggested that the "*dominance of medicine has led most developed economies to invest in health care rather than health*" which is "*neither good for communities or individuals through their life course, nor is it an effective use of resources."* [13]

More broadly, society as well as individuals benefit from good population health. For example, by focusing on giving children the best possible start in life, we could improve attainment in education which in turn has a knock on effect on employment opportunities and health status as people in work tend to be healthier than those who are not in work.[14]

As well as health being of social benefit, the benefits of improving health and reducing health inequalities can be quantified in economic terms. For example in England, analysis for the Marmot Review in 2010 estimated that if everyone had the same death rates as the most advantaged people, those dying prematurely would have had between 1.3 million and 2.5 million extra years of life, and a further 2.8 million years free of limiting illness or disability, and that this inequity accounted for productivity losses of £31-33 billion per year, lost taxes and higher welfare payments in the range of £20-32 billion, as well as additional health care costs to the NHS of over £5.5 billion per year.[15] The analysis demonstrates that the societal value of good health is much broader than reductions in demand for healthcare.

That said, evidence on the effectiveness of a wide range of health promotion and disease prevention interventions that address behaviors that pose a risk to health may be cost effective but not necessarily cost saving. That is to say that many interventions will generate additional health or other societal benefits for additional costs.[16] In a time, when many health systems are facing considerable financial pressure due to rising demand and unhealthier populations, the "ask" of additional resources for additional benefit may prove to be increasingly challenging.

What efforts have been taken at a global level to improve health?

On 12 September 1978, the International Conference on Primary Health Care, held in Alma-Ata expressed the need for urgent action to protect and promote the health of all people of the world. The conference suggested that the "*main social target of governments, international organizations and the whole world community should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life."*[17] The conference's focus on primary health care was defined as essential health care universally accessible to individuals and families in the community through their full participation, and formed an integral part of the country's health system and of overall social and economic development of the community. Key themes included equity, community participation, prevention and health promotion, intersectoral collaboration, the appropriate use of resources and sustainability.[18]

At the time, the declaration met with support but there were concerns about the achievability of "health for all." In 1979 the Rockefeller Foundation sponsored a conference on "health and population in development" in Bellagio, Italy.[19] The conference was based on a paper which proposed "selective primary health care" – an

approach that focused on obtainable goals and cost-effective planning to tackle the main disease problems of poor countries and specifically the most common diseases of infants.[20]

Subsequently, the concept of "selective primary health care" emerged dominant over comprehensive primary health. An example of selective primary health care is UNICEF's GOBI-FFF strategy.[i] [21]

It has been argued that the selective approach has undermined the original aims of primary health care as outlined at Alma Ata (a topic which we can revisit during this Salzburg Global session). Magnussen et al 2004 suggest that the weaknesses of the selective approach include: a focus on tackling disease rather than aiming for wellbeing; donor-driven vertical programs have undermined bottom-up or community-driven approaches and poor coordination which has led to fragmentation, waste and neglecting certain groups.[22] Further, the 2008 World Health Report Primary Health Care: Now more than ever argued that *"left to their own devices health systems do not gravitate naturally towards the goals of health for all through primary health care as articulated in the Declaration of Alma Ata."* The report suggested that instead, systems tended to focus disproportionately on a narrow offer of specialized, curative care.[23]

Despite this tendency to medicalize health, in recent years there has been a focus on *"health in all policies"* approach whereby the importance of multi-sector approaches has been recognized. **Annex A** gives a brief overview of some of key milestones in the development of this narrative.

Finland is often cited as an exemplar whereby a *health in all policies* approach has been developed to include a more general pattern of integrated policy-making involving intersectoral preparation legislation and programs. In addition, the promotion of wellbeing and health as well as the reduction of inequality are considered in all societal decision making.[24] The North Karelia project from the early 1970s acted as an early example of an attempt to bring about behavioral change at a community level. Finland had the world's highest rate of deaths from coronary heart disease in the 1960s with the highest rates being in the province of North Karelia. The aim of the project was to transform the social and physical environment of the province and to change the general risk-related lifestyles in the area through community-based actions targeted at the whole population and not only those people at high risk of coronary heart disease. During the initial 5-year period of the project, there was evidence of changes in risk-related lifestyles and risk factors and this was associated with a substantial reduction in population-level rates of cardiovascular disease. This was replicated at a national level following the spread of project interventions.[25]

While the health in all policies approach resonates with many working within health, we must also have a compelling argument as to the business case for health that resonates with key influencers and stakeholders in sectors outside of health. With many developed countries facing austerity measures, solutions must be grounded in (or at least recognize) the political realities of financial constraint and wider economic interests. Political decisions may not always prioritize health if those decisions could be seen to go against priorities for other ministries or government department.

Dr. Margaret Chan addressing the 8th Global Conference on Health Promotion in June 2013 in Helsinki addressed the challenges of government pursuing some health policies when those policies are in direct contrast with industry interests stating that "*Efforts to prevent non-communicable diseases go against the business interests of powerful economic operators. In my view, this is one of the biggest challenges facing health promotion...Let me remind you. Not one single country has managed to turn around its obesity*

i Growth monitoring, oral rehydration therapy for diarrhoea, breast feeding promotion, immunisations, family planning, food supplementation and female literacy.

epidemic in all age groups. This is not a failure of individual will power. This is a failure of political will to take on big business."

What do we know about the determinants of health?

If we accept the individual and societal benefit from the original Alma Ata statement then we need a broader understanding of the determinants of health.

The WHO defines the social determinants of health as the "*conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life."* [26] These factors can include people's access to health care, schools and education; their conditions of work and leisure; their homes, communities, towns or cities; and their chances of leading a flourishing life. [27]

We know that the challenges in addressing health are too big for health care services to attempt to tackle in isolation. Estimates suggest the proportionate contribution to reduction of premature death is 40% in behavioral patterns of individuals, 30% genetic predisposition, 15% social circumstances, 10% short falls in health care and 5% environmental exposure although these factors are not mutually exclusive.[28]

In 2008 WHO Commission on Social Determinants of Health called for three steps to tackle health inequalities caused by unfair economic arrangements, poor social policies and bad politics. The report noted the importance of a multi-sector approach spanning beyond health organizations. The three main recommendations were to improve daily living conditions, tackle the inequitable distribution of power, money and resources, and set up systems for data collection and monitoring.[29] The Commission's chair Professor Sir Michael Marmot was asked to chair an independent review to consider the most effective strategies for reducing health inequalities in England.

The review, Fair Society Healthy Lives, found that the lower a person's social position, the worse his or her health, and recommended that action should focus on reducing the gradient in health with action across all of the social determinants of health. Marmot focused on taking action on six policy objectives:

- Giving every child the best start in life;
- Enabling all children, young people and adults to maximize their capabilities and control over their lives;
- Creating fair employment and good work for all;
- Ensuring a healthy standard of living for all;
- Creating and developing health and sustainable places and communities
- Strengthening the role and impact of ill health prevention.[30]

In other contexts, a different set of priorities might be more appropriate. For example, the Boston Foundation established an annual report card system in 2011 for Boston which includes indicators in areas such as investments in health and wellness, access to healthy foods, physical activity and citizen education. [31] From 2014, the report card was re-framed to focus on early childhood, schools, food, healthy living by design and public health and health care. [32]

How can we move the agenda forward?

The Robert Wood Johnson Foundation has proposed a new vision to help build a national movement to create a culture of health within the United States based upon 10 core principles[ii] focusing on the broader sense of what being and staying healthy means rather than just viewing health through the lens of health care.[33] The Foundation seeks to change approaches and processes so that traditional health delivery settings are connected with the community settings that influence health so that all organizations promote the health and health care of populations, promote health and health care equally, are aligned across sectors, and operate together rather than in isolation. [34]

Over the course of the Salzburg Global Seminar session we hope to understand more about the interventions and approaches that might have the greatest impact by considering the following:

- **What are the key social determinants of health and what policy choices do they present?** We would like to understand whether focusing on specific determinants of health might be more impactful or cost effective. Inevitably there has to be a trade-off between different services or services users and spending priorities which may not be palatable to politicians or the public. How does this trade-off apply in your own country? What specific strategies can you take to influence the policy decision-making process?

- **What are the points of leverage in support of health and wellbeing? Where would investment therefore likely have the greatest impact?** Looking at life course approaches, how do we identify what support individuals need at different stages to maximize their health and wellbeing? Should different life course stages be prioritized (for example early years) if they are more cost effective? Should we use tools such as risk stratification to determine which people at which life stages should be prioritized? How do we engage effectively with communities and individuals to better define and act on their health values? How can health communication be enhanced in a changing media environment?

- **In which countries has a shift to holistic health started and what have been the contexts, drivers and benefits? Where that shift has been held back, what have been the obstacles?** How can we learn and spread best practice internationally? What has worked best in the promotion of health and wellbeing among civil society and non-government actors, and under what circumstances? How can such initiatives and the necessary resources be maximized? Where appropriate, how could and should they be coordinated with government cross-sectoral policies?

- **How do authorities at every level of the system need to adapt to support health most effectively?** Given legacy systems, short-term political pressures and vested interests, it is difficult for key leaders in government, business or civil society to institute the necessary change. They are in

[ii] (1) good health flourishes across geographic, demographic and social sectors, (2) attaining the best health possible is valued by society, (3) individuals and families have the means and opportunities to make choices that lead to the healthiest lives possible, (4) business, government, individuals and organisations work together to build healthy communities and lifestyles, (5) everyone has access to affordable, quality health care, (6) no-one is excluded, (7) health care is efficient and equitable, (8) the economy is less burdened by excessive and unwarranted health care spending, (9) keeping everyone as healthy as possible guides public and private decision-making and (10) Americans understand that everyone is in it together.

need of advice not just about what they should do, but how they can do it. Are there examples you can share about specific policies at different levels that have supported health in your country?

- **How do we align market interests with health and work best with business or where necessary, how do we best address instances of market failure? And what impact does the health of a population have in terms of social capital and productivity?** These questions may be some of the most difficult to tackle and there is a fundamental issue as to what the relationship between business and health should be but unless there is a strong case that speaks to people outside of health promotion, it will be challenging to build broad coalitions.

Above all, we are keen for this conference to move us on from various international declarations and to re-set the agenda for health by:

- Building on participants' experience of factors and cross-sector collaborations which maintain and promote true health and wellbeing;
- Understanding why we have become hooked on health care and what is needed to change this trend and reduce our dependence;
- Developing a sequence for action and investment by health care providers and funders to support a holistic strategy for health;
- Indicating where providers and governments, from local to national, can act most effectively across domains and levels; and
- Charting the business case for health, identifying where employers, civil society organizations and other stakeholders can best intervene and engage with business leaders.

Over the course of the Salzburg Global Seminar program, participants will have the chance to:

- Develop a set of strategic principles contextualized in country and thematic plans that will include recommendations for policy and collaboration, influencing government policy, foundation grant-making, civil society engagement, and research agendas;
- Identify best practice in communication with audiences about health and innovative ways of measuring the impact of different initiatives;
- Learn about what worked/didn't work in other countries and how those approaches may be adapted in your country.

Following the session, there will be support through Salzburg Global Seminar for ongoing cross-border learning and collaborations among participants and the institutions they represent through a contact list and an email listserve plus other electronic communication, and future global and regional meetings in person. There will be daily bulletins from the session and a report as starting points for continuing discussion.

Annex A: Other important influences in the health in all policies agenda

1986: International conferences on Health Promotion

During the first health promotion conference in 1986, the Ottawa Charter for Health built on the Alma-Ata declaration and set out actions to achieve *"health for all"* by the year 2000. The Conference declared that: "*Health is a positive concept emphasizing social and personal resources, as well as physical capacities…Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members."*

Two years later in 1988, the Second Conference on Health Promotion in Adelaide, recommendations on healthy public policy outlined that health promotion efforts require "*an integrated approach to social and economic development which will re-establish the links between health and social reform.*" [35]

Healthy cities initiative

The healthy cities initiative has aimed to place health high on the agenda of decision-makers and promote comprehensive strategies at a local level for health protection and sustainable development. A healthy city aims to create a health-supportive environment and to achieve a good quality of life as well as supplying access to health care. The first healthy cities programs launched in developed countries from 1986 onwards.[36]

2000: The People's Charter for Health

The People's Charter for Health was formulated and endorsed by the participants of the Frist People's Health Assembly held at Dhaka, Bangladesh in December 2000. The charter outlines that "*within the health sector, failure to implement the principles of primary health care, as set out in the Alma-Ata declaration, has significantly aggravated the global health crisis. Government' and the international community are fully responsible for this failure."* The Charter outlined that it was essential to build a concerted international effort to prioritize "health for all." [37]

2007: Lisbon Treaty – health in all policies at a European level

Article 168 of the Lisbon Treaty (signed by the heads of state and government of the 27 EU Member States on 13 December 2007)[38] outlines that *"a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities"* and that *"union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health."* [39]

2011: UN high-level meeting on the prevention and control of non-communicable diseases

In 2011, the United Nations held a high-level meeting on non-communicable disease prevention and control. The political declaration adopted at the UN General Assembly outlined that the threat of non-communicable diseases represents one of the major challenges for development and may lead to increasing inequalities between countries and populations. The General Assembly referred to a "health in all policies" approach by suggesting that *"effective non-communicable disease prevention and control require leadership and multi-*

sectoral approaches for health at the government level, including as appropriate, health in all polices" in sectors such as education, urban planning and finance. [40]

2011: Rio Political Declaration on Social Determinants of Health

The Rio Political Declaration on Social Determinants of Health was adopted during the World Conference on Social Determinants of Health on October 21, 2011 and confirmed a "determination to achieve social and health equity through action on social determinants of health and wellbeing by a comprehensive inter-sectoral approach.[41]

2015: Sustainable Development Goals

The principles behind selective primary health care were reflected in the United Nations Millennium Development Goals (MDGs) which were designed to sustain development and eliminate poverty through eight ambitious goals. The three health-related MDGs were either disease-specific (such as combatting HIV) or specify a narrow target area (such as improving maternal health).[42] While significant progress has been made against the MDGs, the MDG targets of reducing the under-five mortality rate by 2/3 by 2015 and to reduce maternity mortality by 3/4 will not be met and we are a long way away from achieving the original aims of Alma-Ata to achieve health for all by the year 2000. However, the Sustainable Development Goals (SDGs), set to replace the MDGs do take a more comprehensive and broader approach to tacking global health issues.

Building upon the Millennium Development Goals (MDGs), the Sustainable Development Goals (SDGs) focus on 17 goals agreed on the September 25, 2015 which include resolutions to end poverty, end hunger and reduce inequality within and among countries. With specific reference to health, Goal 3 is to ensure healthy lives and promote wellbeing for all at all ages. This broad-brush approach is quite different to the more specific health MDGs which focused on improving maternal health, reducing child mortality and combating HIV/AIDS, malaria and other diseases.[43] While these areas remain important within Goal 3, other targets are included which take a broader population health perspective. For example the targets to:

- Reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing by 2030;
- Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol by 2030;
- Substantially reduce the number of deaths and illnesses from hazardous chemicals; and air, water, and soil pollution and contamination.

Inclusion of the target to reduce premature mortality from non-communicable diseases has been broadly welcomed but there have been warnings that the target is absolute and does not send a signal that achieving this reduction should be done in an equitable or fair way,[44] which could potentially further exacerbate existing inequalities. Unlike the MDGs which targeted developing countries, the SDGs apply to both developed and developing countries.[45]

The SDGs give a global emphasis to prevention and combined with other initiatives focusing on health in all policies could be the catalyst to prompt greater action in tackling health issues.

REFERENCES

[1] Baggott, R (Ed) *Health and health care in Britain*. Third Edition. Basingstoke: Palgrave Macmillan; 2004.

[2] Warwick-Booth, L, Cross, R, Lowcock, D. *Contemporary Health Studies: An Introduction.* Cambridge: Polity Press; 2012.

[3] Warwick-Booth, L, Cross, R, Lowcock, D. *Contemporary Health Studies: An Introduction.* Cambridge: Polity Press; 2012.

[4] World Health Organization. *The Ottawa Charter for Health Promotion***.** Geneva, Switzerland: WHO; 1986 Nov 21 Available from:http://www.who.int/healthpromotion/conferences/previous/ottawa/en/index.html.

[5] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[6] What is health? The ability to adapt [editorial]. *Lancet* 2009;373:781.

[7] *Huber, M, Knottnerus, A, Green, L, Van der Horst, H, Jadad, A, Kromhout, D et al.* How should we define health? *BMJ* 2011;343:d4163 doi: 10.1136/bmj.d4163

[8] Smith, R. *The end of disease and the beginning of health*. BMJ Blogs; 8 July 2008. Accessed via: http://blogs.bmj.com/bmj/2008/07/08/richard-smith-the-end-of-disease-and-the-beginning-of-health/ on 2 November 2015.

[9] Jadad, A. How should health be defined? *BMJ 2008*; 337 doi: http://dx.doi.org/10.1136/bmj.a2900

[10] Saracci, R. The world health organisation needs to reconsider its definition of health. *BMJ* 1997; 314 doi: http://dx.doi.org/10.1136/bmj.314.7091.1409 http://www.bmj.com/content/314/7091/1409

[11] Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.

[12] UN General Assembly, *Universal Declaration of Human Rights*, 10 December 1948, 217 A (III), available at: http://www.un.org/en/universal-declaration-human-rights/

[13] Leppo, K, Ollila, E, Peña, S, Wismar, M, Cook, S (eds). *Health in All Policies Seizing opportunities, implementing policies. Finland:* Ministry of Social Affairs and Health; 2013

[14] Shah, D. *Healthy worker effect phenomenon. Indian J Occup Environ Med. 2009 Aug; 13(2): 77–79. doi: 10.4103/0019-5278.55123.*

[15] Marmot, M. *Fair Society Healthy Lives: The Marmot Review*. UCL Institute of Health Equity; 2010.

[16] Merkur, S, Sassi, F, McDaid, D. Promoting health, preventing disease: is there an economic case? World Health Organization; 2013

[17] Declaration of Alma-Ata: International conference on primary health care, Alma-Ata, USSR, September 6-12 1978. Accessed via http://www.who.int/publications/almaata_declaration_en.pdf on 2 November 2015.

[18] Declaration of Alma-Ata: International conference on primary health care, Alma-Ata, USSR, September 6-12 1978. Accessed via http://www.who.int/publications/almaata_declaration_en.pdf on 2 November 2015.

[19] Cueto, M. The origins of primary health care and selective primary health care. *Am J Public Health.* 2004 November; 94(11): 1864–1874.

[20] Walsh and K. Warren, Selective Primary Health Care: An Interim Strategy for Disease Control in Developing Countries. *New England Journal of Medicine* 301, no. 18 (1979): 967–974.

[21] UNICEF. *UNICEF's GOBI-FFF Programs*. Accessed via: http://rehydrate.org/facts/gobi-fff.htm on 9 November 2015.

[22] Magnussen, L, Ehiri, J, Jolly, P. Comprehensive versus selective primary health care: lessons for global health policy. *Health Aff (Millwood).* 2004 May-Jun;23(3):167-76.

[23] WHO. *Primary Care: Now more than ever*. WHO; 2008.

[24] Leppo, K, Ollila, E, Peña, S, Wismar, M, Cook, S (eds). *Health in All Policies Seizing opportunities, implementing policies. Finland:* Ministry of Social Affairs and Health; 2013

[25] Puska, P. The North Karelia Project: 30 years successfully preventing chronic diseases. *Diabetes Voice.* May 2008. Volume 53. Special Issue

[26] World Health Organization. The Social Determinants of Health. Accessed via: http://www.who.int/social_determinants/en/ on 26 November 2015.
[27] Commission on Social determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. World Health Organization
[28] McGinnis, J.M, Williams-Ruso, P, Knickman, J. The Case for More Active Policy Attention to Health Promotion. *Health Aff.* March 2002 vol. 21 no. 2 78-93.

[29] Commission on Social determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health*. World Health Organization

[30] Marmot, M. *Fair Society Healthy Lives: The Marmot Review*. UCL Institute of Health Equity; 2010.
[31] Healthy People/Healthy Economy. First Annual Report Card 2011. The Boston Foundation; 2014. Accessed via: http://www.tbf.org/tbf/56/hphe/~/media/3113120178FE40FA981CE00500D6B346.pdf
[32] Healthy People/Healthy Economy. Annual Report Card 2014. The Boston Foundation; 2014.
[33] Robert Wood Johnson Foundation. Building a Culture of Health 2014. *President's Message Risa Lavizzo-Mourey, MD, MBA, President & Chief Executive Officer.* Robert Wood Johnson Foundation; 2014. Accessed via: http://www.rwjf.org/content/dam/files/rwjf-web-files/Annual_Message/2014_RWJF_AnnualMessage_final.pdf on 10 November 2015.
[34] Plough, A. Building a Culture of Health: A Critical Role for Public Health Services and Systems Research *American Journal of Public Health | Supplement 2*, 2015, Vol 105, No. S2.

[35] Adelaide Recommendations on Healthy Public Policy. Second International Conference on Health Promotion, Adelaide, South Australia, 5-9 April 1988. Accessed via: http://www.who.int/healthpromotion/conferences/previous/adelaide/en/index2.html

[36] WHO. *Types of Healthy Settings (Healthy Cities*). WHO. Accessed via: http://www.who.int/healthy_settings/types/cities/en/ on 3 November 2015.

[37] People's health movement. *The People's Charter for Health*. People's health movement. Accessed via: http://www.phmovement.org/en/resources/charters/peopleshealth on 3 November 2015.

[38] European Union, Consolidated version of the Treaty on the Functioning of the European Union, 13 December 2007, 2008/C 115/01

[39] European Union, Consolidated version of the Treaty on the Functioning of the European Union, 13 December 2007, 2008/C 115/01 (Art 168) Accessed via: http://www.lisbon-treaty.org/wcm/the-lisbon-treaty/treaty-on-the-functioning-of-the-european-union-and-comments/part-3-union-policies-and-internal-actions/title-xiv-public-health/456-article-168.html on 3 November 2015

[40] *General Assembly resolution 66/2, Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Disease,* A/RES/66/2 (24 January 2012) available from: http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf?ua=1

[41] World Health Organization, World Conference on Social Determinants of Health, Rio de Janeiro, Brazil 19-21 October 2011. *Rio Political Declaration on Social Determinants of Health Rio de Janeiro, Brazil, 21 October 2011*. Accessed via: http://www.who.int/sdhconference/declaration/Rio_political_declaration.pdf?ua=1 on 10 November 2015.

[42] United Nations. The Millennium Development Goals 2015 and Beyond. United Nations Accessed via: http://www.un.org/millenniumgoals/ on 9 November 2015.

[43] United Nations. The Millennium Development Goals 2015 and Beyond. United Nations. Accessed via: http://www.un.org/millenniumgoals/ on 9 November 2015.

[44] Schmidt H, Barnhill A (2015) Equity and Noncommunicable Disease Reduction under the Sustainable Development Goals. *PLoS Med* 12(9): e1001872. doi:10.1371/journal.pmed.1001872

[45] United Nations. Press Kit for the Sustainable Development Summit 2015: Time for Global Action for People and Planet. United Nations. Accessed via: http://www.un.org/sustainabledevelopment/wp-content/uploads/2015/08/FAQs_Sustainable_Development_Summit.pdf on 6 November 2015.