

1 *From Health in All Policies to Health for All Policies: the logic of co-benefits*

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1.1 Introduction: beyond Health in All Policies

Everything affects health, but not everybody thinks health is their business. Health status and outcomes, it is known, are shaped by social, economic and political determinants as diverse as cigarettes, sewers and adult education. That argument has never been guaranteed to persuade interests and people who regard health as somebody else's problem. Sceptics might think that ill health is an individual failing, or something to be solved by hospitals and technology; or inevitable; or simply not a priority relative to some other goal such as fiscal rigour or How do we make the case for health?

Traditionally, health policy “advocates” have framed intersectoral collaboration as “Health in All Policies”, though the impulse to work through other sectors to improve health far antedates the HiAP campaigns of the twenty-first century. HiAP arguments drew upon this widespread recognition that factors outside of health care services determine our health and that this involves many sectors (Ståhl et al., 2006). This understanding draws on arguments dating back to at least the Alma Ata Declaration (Chorev, 2012; Fukuda-Parr, 2018; Lawn et al., 2008; Weber, 2020) and many other documents, including the 2018 Tallinn Declaration (Cylus, Permanand & Smith, 2018). The COVID-19 pandemic and countries' responses to it has made the potential scope of a HiAP approach – of sorts – abundantly clear. During the pandemic, countries have implemented measures to prevent disease transmissions, adjust health systems, control borders and mobility, redirect the economy, and secure civil protection. In order to achieve this, many heads of government and their ministers of health worked closely with all other ministries (education, internal and foreign affairs, transport), departments (agriculture, research and state aid), and sectors (social affairs and transport) (Greer et al., 2022a; Sagan et al., 2021). We have also

seen tremendous pressure to “return to normal”, regardless of whether the epidemiological situation warrants it; the multiplicity of interests and goals in a modern society means that an all-out mobilization for any particular goal is politically unsustainable over time.

The volume of publications and policy attention dedicated to HiAP in global health debates is impressive. WHO’s Helsinki Statement on Health in All Policies described HiAP as “an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts in order to improve population health and health equity” (WHO, 2014). HiAP was the most important international movement to achieve health goals through intersectoral action. Health in All Policies is a “horizontal, complementary policy-related strategy contributing to improved population health. The core of HiAP is to examine determinants of health that can be altered to improve health but are mainly controlled by the policies of sectors other than health.” (Ståhl et al., 2006; Box 1.1). HiAP entailed intersectoral governance or multi-sectoral governance, “coordinated action that explicitly aims to improve people’s health or influence determinants of health. Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors.” (Ståhl et al., 2006; Box 1.1).

Box 1.1 Definitions

Determinants of health refers to factors found to have the most significant influence – for better or worse – on health. Determinants of health include the social and economic environment and the physical environment, as well as the individual’s particular characteristics and behaviours. Social and economic conditions – such as poverty, social exclusion, unemployment and poor housing – are strongly correlated with health status. They contribute to inequalities in health, explaining why people living in poverty die sooner and become sick more often than those living in more privileged conditions.

Social determinants of health can be understood as the social conditions in which people live and work. These determinants point to specific features of the social context that affect health and to the pathways by which social conditions translate into health impacts.

Health is, according to the official WHO definition, a state of complete physical, mental and social wellbeing and not merely the absence of

Box 1.1 (cont.)

disease or infirmity. Within the context of health promotion, health is seen as a resource for everyday life, not the object of living; it is a positive concept emphasizing social and personal resources as well as physical capacities.

Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and therefore improve their health. It represents a strategy within the health and social fields which can be seen on the one hand as a political strategy and on the other hand as an enabling approach to health directed at lifestyles.

Health sector includes government ministries and departments, social security and health insurance schemes, voluntary organizations and private individuals, and groups providing health services.

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Intersectoral action for health could be defined as a coordinated action that explicitly aims to improve people's health or influence determinants of health. Intersectoral action for health is seen as central to the achievement of greater equity in health, especially where progress depends upon decisions and actions in other sectors. The term "intersectoral" was originally used to refer to the collaboration of the various public sectors, but more recently it has been used to refer to collaboration between the public and private sectors. The term "**multisectoral action**" has been used to refer to health action carried out simultaneously by a number of sectors within and outside the health system, but according to the WHO Glossary of Terms, it can be used as a synonym for intersectoral action.

Healthy public policy is, according to the Adelaide recommendations, "characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The main aim for healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible and easier for citizens. It makes social and physical environment enhancing."

Public policy is policy at any level of government and may be set by heads of government, legislatures and regulatory agencies. Supranational institutions' policies may overrule government policies.

Source: Ståhl et al., 2006

Note how these definitions focus on what can be achieved for health by activities in other sectors. HiAP is an analytical tool and frame as a means to an end, which is healthy public policies (Kickbusch, 2010). The Adelaide Declaration called for “healthy public policy” that is “characterized by an explicit concern for health and equity in all policy areas, and by an accountability for health impact. The main aim for healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes health choices possible and easier for citizens. It makes social and physical environment enhancing.” (Box 1.1).

The limitation of Health in All Policies thinking, as with many of the older social medicine and social determinants of health campaigns, is that it frames the issue in unidirectional terms: how can other sectors, such as transport, education or taxation, improve health? The limitation of such an appeal is obvious because it is unclear why other sectors should invest resources or change what they are doing to improve health outcomes (Lynch, 2020). Transport, education and finance ministers often have other goals of more importance, and more accountability for outcomes other than health. Short of a total mobilization of government for health – something like the COVID-19 responses of 2020 in Europe – we should expect resistance from all sorts of interests to HiAP. That is exactly what HiAP researchers and practitioners found, for all that a large literature catalogued cases and examples of inter-sectoral action for health (Bacigalupe et al., 2010; Bekker et al., 2017; Greszczuk, 2019; Kickbusch, 2010; Koivusalo, 2010; Leppo et al., 2013; De Leeuw, 2022; McQueen et al., 2012; Marmot et al., 2012; Ståhl et al., 2006). If there were not a large, well-timed and sustained political push for HiAP, the effort was likely to founder.

Or was it? While much HiAP literature is produced in and for health policy circles, and therefore emphasizes the impact of its policies on health, a quick look at the actual literature suggests that writers and practitioners alike were actually seeking win-win solutions. Rather than simply asking schools to feed children better quality food, they were highlighting the educational benefits of improved nutrition (Behrman, 1996; Maluccio et al., 2009). Rather than simply asking municipal governments to encourage active transportation through changes to the built environment, such as bike lanes and wider pavements, they also highlighted the benefits to cities’ merchants, nightlife, and tourist appeal (Mueller et al., 2015; Poirier, 2018).

In other words, successful HiAP might be half of a win-win solution, in which better and more sustainable cities or better test scores for children come *with* rather than at the expense of health. It stands to reason, because the causal links connecting good health and reduced health inequalities with better overall and more equal outcomes in many arenas are well rehearsed (Greer et al., 2022b). It also stands to reason because health care systems can be such large actors, with strong independent effects on their societies, as employers, owners of large-scale infrastructure, high-technology industries and purchasers of goods and services. Finally, it stands to reason that the successes were not purely HiAP because the space that HiAP seems to leave for its advocates is simply so cramped and small; the amount of policy change associated with HiAP goes beyond what we should expect if it were really just about inducing well-established and powerful organizations to change their priorities on the basis of some persuasive arguments alone. Once we start to look for win-win solutions in HiAP, there are many to be found.

We call these win-win solutions the *logic of co-benefits*. Co-benefits occur when two or more goals result from the same policy. Rather than a zero-sum model of policy, in which resources and political attention are finite and a gain for health is a loss for another sector, the logic of co-benefits directs our attention to the areas in which a gain for health and health systems is a gain for other goals as well. Thinking this way opens up new political vistas: of political strategies, of governance mechanisms, of whole-of-government and whole-of-society coalitions of many different actors who can benefit from a policy or goal. It also brings the health politics literature more in line with the broad approach of political scientists, who emphasize coalitions of different interests and appeals to broad swathes of the public as part of the formula for political and policy success.

In this book, the basic question we are asking is: how do we develop collaboration between sectors to achieve goals that cannot be attained through better health and health policies? Put differently, how can we better understand and communicate the health effects and co-benefits that intersectoral action can produce? The book draws on and makes a case for changing the argument about intersectoral action, from one focusing on health and the health sector as the main beneficiary to one based on co-benefits, focusing on benefits for all sectors. It makes the case for a *Health for All Policies* approach that focuses on co-benefits between sectors.

This book uses the Sustainable Development Goals as the framework for identifying goals across sectors. The next section introduces and discusses the SDGs. The SDGs are a set of global goals, broken down into specific targets and indicators to monitor. SDG3, “Good health and wellbeing”, is well known in global health circles. Its goals and the policies needed to attain them have long been discussed, enacted and evaluated. But a moment’s reflection on the other sixteen SDGs highlights the extent to which health and health policies can contribute to their attainment.

It first frames the topic in terms of two causal axes (Greer et al., 2022b). One is the impact of improved health status on other SDGs – for example, better health can lead to better educational and employment results. This is ground often trodden by economists and other quantitative researchers, though qualitative research on the relationship between health and social behaviour is vast and informative. It is the area in which we focus on findings such as the destructive relationship between HIV status and employment (Levinsohn et al., 2013). The other is the impact of health systems and policies on other sectors. The health sector is a major employer, driver of economic activity, and user of infrastructure; all of these can contribute to other goals, such as equal access to good jobs and economic development.

In terms of policies, we should not understate the impact of health policies and sectors through mechanisms other than improved health. Health in All Policies was, more often than not, a call to action for other sectors; Health *for* All Policies is both a call to improve health and a way to achieve goals beyond health. Furthermore, it calls for the health sector to do better in understanding and directing its impact on the world beyond the health care it provides. How can health sector expenditure, combined with attention to sustainable cities, contribute to urbanism; or, combined with industrial policy, contribute to economic development; or, combined with an appreciation of climate change, contribute to stopping and mitigating the harms of global heating?

1.2 Attaining the SDGs: the role of health sector co-benefits

If the world has shared goals, they are the Sustainable Development Goals (Fig. 1.1). The SDGs are seventeen objectives covering issues as different as eliminating poverty, access to clean water and sanitation,



Fig. 1.1 The Sustainable Development Goals (SDGs) for 2027

and climate action, agreed upon by heads of government through the UN. They are not just the framework for UN action, but also receive at least some attention in government and other organizations' planning; for example, the European Union has replaced its Europe 2020 goals, in important mechanisms such as the European Semester, with the SDGs (Greer et al., 2022b). Even for those who are cynical about the actual adherence of governments to all seventeen goals, the SDGs provide a way to speak about widely held and important objectives. They are, in their intricacy, like a basket: while an individual strand might not be of interest, once woven together they encompass shared human goals.

The concept which became the Sustainable Development Goals is about as old as international law. Still, their core context is that of the UN and the international system as founded after the Second World War (Cueto, Brown & Fee, 2019). In 1948, Article 25 of the Universal Declaration of Human Rights stated that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services" (United Nations General Assembly, 1948). By the 1970s the idea of the right to health was developed further in the World Health Organization's (WHO) Health

for All promotion, which envisioned securing the health and wellbeing of people worldwide. In combination, access to basic health services was affirmed as a fundamental human right in the Declaration of Alma Ata in 1978 (primary health care is key). Some goals included that at least 5% of the gross national product should be spent on health, at least 90% of children should have a weight for age that corresponds to the reference values, and people should have access to trained personnel for attending pregnancy and childbirth. In 2000, this concept was expanded in the form of the Millennium Development Goals (MDGs), which encompassed eight international development goals for 2015.

In 2015, the Sustainable Development Goals, also known as the Global Goals, were adopted by the United Nations as “a universal call to action to end poverty, protect the planet, and ensure that by 2030 all people enjoy peace and prosperity” (United Nations Development Programme, 2022). The 17 sectoral goals, see Fig. 1.1, come with numerous specific targets and indicators to propose suitable programmes to achieve the various goals. The SDGs are special insofar as they go further than many of their predecessor international policies. Health for All (HFA), the WHO health policy framework, for example, stressed the need for intersectorality but only defined targets for the health sector. The MDGs went further as they included targets on social development. In this respect, the SDGs can be seen as a consequential development as they literally comprise all policies and sectors. The SDGs are also very relevant as a platform for intersectoral programmes because they are more widely known than their predecessors and have been adopted by the entire UN System, the European Commission and many Member States.

Combining the notion of HiAP with this new set of goals, the idea is to recognize that an action in one sector can positively affect the outcome in other sectors. That said, if the goal is to advance wellbeing in our societies through strengthening the link with health, the SDGs can provide an excellent platform for intersectoral programmes. While the SDGs are not the only way to design intersectoral programmes, and the SDGs are not the only conceptual framework for human development, they are used here in this study as examples of how such programmes could be designed.

Box 1.2 How health care systems can help or hurt other SDGs: the case of a hospital

Health *for* All Policies means we need to look at ways that the health sector and health policies do or do not contribute to broader social goods. Imagine the development of a hospital, newly built, efficient, and located on the outskirts of the city, in an area primarily accessible by car. What is the hospital's impact on key policies highlighted in the SDGs? What could be done better if we were to seek co-benefits rather than simply the efficient production of health care services?

Climate action (SDG13) calls for a move to carbon neutrality while hospitals are a key source of greenhouse gas (GHG) emissions (Tennison et al., 2021). In the UK, the NHS is responsible for 4% of total national carbon emissions, of which 79% come from primary care and community services (NHS, 2012). Of these emissions, hospitals, which are large buildings requiring 24/7 energy for heating, ventilation, lighting and advanced energy-intensive medical devices and pharmaceuticals, are the greatest contributor (Eckelman & Sherman, 2016). NHS-related travel explains 3.5% of all road travel in the UK, making travel the 5th highest contributor of GHG emissions in the hospital system following medical equipment, pharmaceuticals, business services, fuels and electricity (NHS, 2012). The high use of energy in hospitals also creates an opportunity for hospitals to impact the SDG of accelerating renewable energy use (SDG7). Currently, most hospitals rely on non-renewable sources of energy. Studies have shown switching to renewable sources can contribute to sustainable development goals while also creating savings for hospitals (Prada et al., 2020; Sala, Alcamo & Nelli, 2016; Vaziri, Rezaee & Monirian, 2020).

In addition to energy, hospitals are large consumers of water impacting SDGs 6 and 12: Clean Water and Sanitation, and Responsible Consumption and Production, respectively. In 2017 the NHS utilized water equivalent to the total water use of Estonia (Sala, Alcamo & Nelli, 2016). In Spain, 900 hospitals account for 7% of the total use of water in the country, which amounts to roughly \$600 million euros (Garcia-Sanz-Calcedo et al., 2017). The use of water in hospitals comes mostly from direct use (35–70%), research and treatment (15–40%) and food preparation (5–25%). Studies find this elevated water use could be limited with more responsible monitoring and auditing of water use (McGain & Naylor, 2014).

Hospital development can also impact SDGs of decent work (SDG8) and reduce inequality (SDG10). Hospitals are staff intensive and offer

Box 1.2 (cont.)

high opportunities for employment in the regions where they are located. In France, an average public hospital employs 876 people (Clark & Milcent, 2011). Locating these hospitals in suburban areas may provide employment opportunities in already prosperous areas, increasing employment inequity between suburban, urban and rural communities. In addition to employment inequality, hospitals and hospital location can increase inequality in health care access. Reliance on political will for funding and development of hospitals may lead to a lack of access to hospital care in marginalized communities (Matheson et al., 2018). Even when hospitals are accessed by these marginalized communities, poor hospital culture, such as embedded systematic racism, may lead to differences in treatment among groups (Matheson et al., 2018). Additionally, hospitals are generally resistant to change and show a lack of responsiveness to community needs, which has a greater impact on quality health care access in marginalized communities (Matheson et al., 2018).

Box 1.3 Why equity matters

There are two reasons why health equity is a necessary part of Health for All Policies.

The first is ethical: equity is a compelling value in its own right. Not only is it explicitly the purpose of some SDGs (5, gender equality, and 10, reduced inequalities), it is a goal spread throughout the other SDGs, whether that means the commitment to equal education in SDG4 or the commitment to good work and jobs for *all* in SDG8. Even if we disregard the SDGs, equity is a fundamental value of health and social policy, and policies that disregard equity are ethically problematic.

The second is simply that inequity can drag down a whole society. Unusually bad outcomes for a particular group that is victimized in some way – by racism, economic inequality, gender discrimination or similar mechanisms – will drag down the results for the whole country. The tails of the distribution affect the mean. The United States, for example, has the highest maternal mortality among rich countries. This is because of unusually high *Black* maternal mortality due to racism (Declercq & Zephyrin, 2020). The United States' overall bad outcome is not a result of processes that affect every person giving birth; it is a result of inequity, and addressing the overall bad outcome requires addressing the inequity.

Attaining the SDGs without attention to health equity is simply not possible.

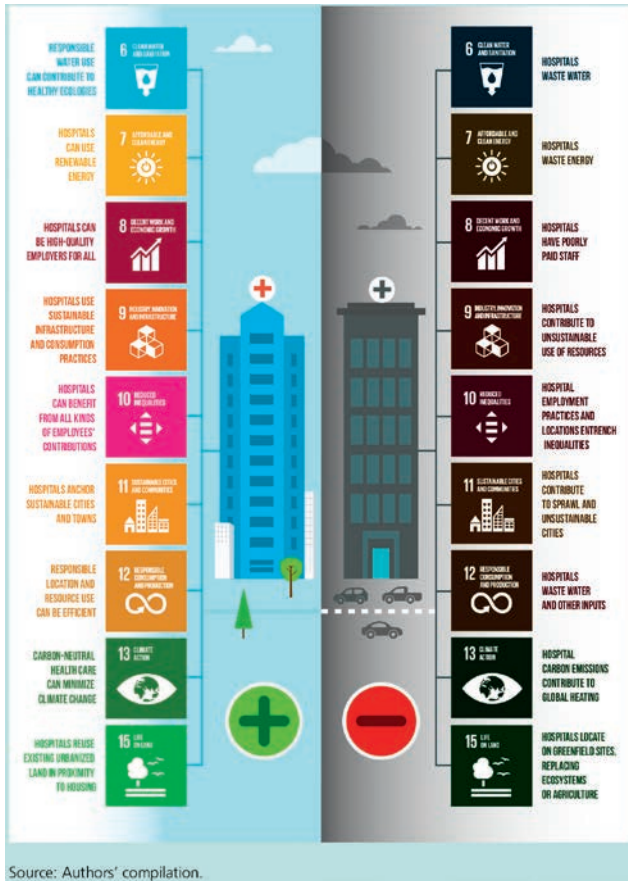


Fig. 1.2 Health care for all policies?

1.3 Summary of subsequent chapters

The book continues with Chapter 2 presenting the two causal chains that link health outcomes and health policies and organizations to other SDGs. We identify the methodological challenges of identifying and measuring co-benefits, discussing the quantitative, modelling and policy analysis approaches that can be used to forecast the effects of Health for All Policies approaches and then evaluate them. In Chapter 3, we address the weak spot of all intersectoral action: the political and governance challenges. It presents a framework for identifying promising

areas for intersectoral action based on the salience and conflict associated with the issue, then identifies governance challenges and presents a set of techniques for addressing the challenges. Chapter 4 identifies some key lessons and policy directions.

Chapters 5–13 cover nine selected SDG cases including, SDG1 no poverty, SDG4 quality education, SDG5 gender equality, SDG8 decent work and economic growth, SDG9 industry, innovation and infrastructure, SDG10 reduced inequalities, SDG11 sustainable cities and communities, SDG13 climate action and SDG17 partnerships for the goals and their relationship to SDG3 health. Each of these chapters will showcase an in-depth analysis of the specific SDGs. In addition, country examples will depict the possibility of intersectoral collaboration between the SDG in question and SDG3 health using the analytical frameworks outlined in Chapters 2–4.

Chapter 5 discusses SDG Goal 1: “Ending poverty in all its forms everywhere”. It argues that poorly designed coverage policies are a significant problem in the fight against poverty as they leave some of the sickest patients on the brink of financial ruin. To improve health coverage design, policies are needed to ensure that financially vulnerable people are not exposed to further hardship as a result of using health services. This chapter uses the cases of Latvia and Germany to demonstrate the relative importance of copayment design and exemptions in reducing poverty. Increasing public investment in health overall is a good first step; however, other important action points include full population coverage, a comprehensive benefits package and limited user charges to improve health outcomes and help eradicate poverty.

Chapter 6 looks at SDG4: quality education. Due to the fact that education is strongly associated with life expectancy, morbidity and health behaviours, it is widely recognized that health and education are mutually influential. While the focus has primarily been on the impact of education on health, advancing health and wellbeing remains a critical pathway to achieving education and lifelong learning. As such, a reorientation of systemic thinking and practice that builds on health and wellbeing as central elements of achieving quality education during the life course is key to achieving SDG4 quality education.

Chapter 7 argues that health care needs to include equity and access for women, men and all other genders. The reverse is also necessary: gender equality and human rights need health equity. This strong connection between SDG3 (health) and SDG5 (gender) creates specific

conditions of co-benefits. However, bringing a gender lens to the debate over SDG co-benefits raises more general questions about universalist policy concepts, which assume “neutrality” and do not adequately respond to policy contexts and stakeholders’ diverse needs and interests. This chapter ultimately calls for increased attention to gender equality and intersectionality, thereby capturing and addressing the importance of participatory governance more effectively. Two empirical case studies illustrate an optimum scenario of health action creating gender equality co-benefits with a focus on women’s health.

Chapter 8 asserts that decent work and economic growth benefits greatly from a healthy population. In this vein, health policy itself can promote improved work and employment by making health sectors better employers. There are many opportunities to improve the quality of jobs and reduce inequalities, beginning with addressing particular management behaviours in particular units, to strong and well enforced anti-discrimination law, and paying a higher minimum wage. The political difficulty of making such adjustments, especially in the eyes of managers and policymakers, takes the form of added costs to organizations and reduced pay differentials that benefit higher-paid workers. The goal is thus to focus efforts on political actors such as unions and civil society that will support SDG8. A case study of Romania presents an overview of policy actions taken to address health workforce shortages, by tackling issues related to recruitment, retention and international mobility of health workers.

Chapter 9 points to the fact that initiatives such as technology transfer and local production of pharmaceuticals in low- and middle-income countries can be a means to promote industrial and innovation goals (SDG9), while meeting health needs. The main goal is to strengthen regulatory systems through local production. This will not only allow for the increased assessment of manufacturing practices and heightened quality control but will also provide additional opportunities to train and develop human resources, develop new skills, and promote local industrial development. The cases of Brazil and Mozambique illustrate the intersectoral initiatives between health and industrial policies and how they have ultimately led to increased health benefits.

The goal of Chapter 10 is to demonstrate how SDG3 (health for all) can work with SDG10 (reduce inequalities) to fight longstanding societal inequalities. One of the first steps is the creation of a National Health Insurance (NHI), whose goal is to cover the entire population

with adequate health care at an affordable price. Health and health outcomes are, however, not only affected by the provision or access to health care and health services. They result from multidimensional and complex factors linked to the social determinants of health. So, while NHI may reduce inequality and inequity in health care, further attention will need to be placed on socioeconomic inequality given the social and economic disparities among the population groups in the country.

Chapter 11 argues that by using a multisectoral urban governance approach that emphasizes health, cities can expand successfully and equitably while leaving no residents behind. Two case studies will provide examples of interventions that have been implemented through a multisectoral approach, using urban planning strategies to impact health. As countries look to improve their commitment to building sustainable, healthy, inclusive and resilient cities (SDG11), stronger coordination across multiple sectors is needed to ensure policies and programmes targeting equitable growth are in place to prevent the negative consequences of rapid urbanization.

Chapter 12 shows how health systems and policy can address climate change. It uses the case study of the city of Toronto in Canada to offer lessons for directly involving health systems in subnational climate action as policy stakeholders and implementors, and the co-benefits health system engagement brings to promote climate action intersectorally. Health Systems as Stakeholders and Implementors in Climate Policy Change (SDG13) may take immediate steps through both: 1) participating in local planning for adverse weather events, and 2) making direct infrastructure investments in sustainable buildings and materials.

Chapter 13 examines the wide-ranging and often poorly understood SDG17 (Means of Implementation) in the context of health policy and governance. It fundamentally asks: How can health policies and systems contribute to achieving goals from SDG17? The author argues that there are significant synergies between health policy and SDG17 as many of the factors that potentially make “sustainable development” possible require healthy populations and functional health systems. When health and sustainable growth goals align, good population health, resting on environmentally sustainable food chains, adequate support for public health systems, good access to health care, and good enough governance for health, can provide benefits to the global economy and help to move towards a model of sustainable development.

1.4 Conclusion

Health for All Policies is a framework emphasizing co-benefits: the ways in which improved health or better health systems and policies can attain other goals. In terms of the SDGs, it captures the extent to which better health status, and use of health budgets, policies and infrastructures, can contribute to all of the SDGs, whether fairly obvious ones (health enables education) to ones that require more thought (health care systems' procurement and waste disposal systems affect life under the seas).

The case for co-benefits is not just that it shows what health policy can do for other goals. It is not just that it shows what health policy *should* do for other goals such as sustainability or reducing gender and other inequalities. It also opens up new perspectives on coalitions, politics and governance. It puts the focus on win-win solutions and the coalitions that can create them. Political and policy changes often happen when coalitions change, and one way to promote that is to identify new shared goals and agreements on policies.

This book is part of a broader package of work (Greer et al., 2022b), and focuses primarily on the ways in which health care *policies and systems* can produce co-benefits for other sectors, from reducing poverty (SDG1) to international partnership (SDG17). Other work in the package, drawing on the methods and literature discussed in Chapter 2, will focus on the co-benefits of improved health status. This book speaks to health care: one of the largest, most geographically distributed, technology-heavy, employment-heavy, education-focused and infrastructure-heavy sectors in the world. Health care purchasing, employment, research, training, estate, hiring and waste disposal decisions shape much of the world around us. What are the co-benefits of health systems and policies – and what can health policymakers do to make health policy for all policies?

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