

Health in All Policies

Salud en todas las políticas

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Chronic diseases are a problem that, as many others, exceed the health sector and relate, accompany and deepen the inequalities that make up the social matrix of our country.

If we add the difficulties of a health care model that does not include the ailing population, does not understand it and continues to be traditionally structured and organized to solve acute problems, people with risk factors and patients become “sufferers” not only of their illnesses, but also of the health system as such (which based on its “organization” should be called disease system), since following its logic, it is able to devote large amounts of resources to the acute manifestations of diseases, and not to avoid their occurrence.

Late detection, the pilgrimage through various services and the difficulty in accessing to regular and sustained treatments are just some of the steps of a path that leads to a final inescapable goal: greater inequity.

However, there is strong evidence that the organization of health services, with a patient-centered scope, is a remarkable tool to improve their care. Risk factor management, coordination between primary health care and hospitals and medication provision concentrate the effectiveness of primary health care and go beyond the simple measure of increasing access. Incorporation of self-control, with the support of the patient throughout treatment, is a clear example of this. The work presented by Mariani et al. in this issue of the Journal (1) on the decrease of stroke mortality and its relationship with free antihypertensive drug provision through the Remediar program, is a clear example of a public policy focused on reducing inequities, inasmuch as it has clearly favored the poorest population.

However, the challenge for the health system remains, as the development of risk factors associated with cerebrovascular disease evidence an adverse result throughout the three National Risk Factor Surveys. Studies performed by our university team show significant differences in the occurrence of cardiovas-

cular risk factors associated with income, education level and explicit health coverage, with the most unprivileged and less educated classes presenting the highest prevalence of these factors, a situation that persists over time. The prevalence of obesity is a significant example: 28% among people with primary education versus 14% with higher education, and similarly for the frequency of hypertension, which in the first group doubles that in the second.

The prospect of inequalities is completed with the association between place of residence and risk factors, where the map shows several Argentine regions, with Northwestern and Northeastern regions having 18% more chance of overweight and obesity and 20% more probability of having hypertension than the City of Buenos Aires and Greater Buenos Aires, reflecting differences in the levels of access to healthy food and services and in socioeconomic variables.

It is unacceptable, for a society with our level of development, that place of birth, income characteristics or access to quality education, become factors that constrain not only quality of life, but decide the time and manner of death.

The great challenge of building an Argentina for everyone must be a priority of public policy in general and health in particular. Although the health system and services are in debt in terms of efficiency and effectiveness, the contribution of other sectors is essential to achieve that goal.

Thus, we need a health policy and health in all policies.

Conflicts of interest

None declared.

(See authors' conflicts of interest forms in the website/ Supplementary material).

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