

Health inequalities: a global perspective

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Abstract *The objective of this article is to present health inequalities as a global problem which afflicts the populations of the poorest countries, but also those of the richest countries, and whose persistence represents one of the most serious and challenging health problems worldwide. Two components of global inequalities are highlighted: inequalities between groups within the same society, and inequalities between nations. The understanding that many of these inequalities are unjust, and therefore inequities, is largely derived from the inequalities that are identified between the various social groups of a given society. Inequalities between different societies and nations, while relevant and often of greater magnitude, are not always considered to be unjust. There have been several proposed solutions, which vary according to different theoretical interpretations and explanations. At the global level, the most plausible thesis has focused on improving global governance mechanisms. While that latter are attractive and have some arguments in their favor, they are insufficient because they do not incorporate an understanding of how the historical process of the constitution of the nations occurred and the importance of the position of each country in the global productive system.*

Key words *Health inequalities, Social determinants of health, Social inequity, Global health*

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Introduction

Human society, which comprises the more than seven billion individuals who inhabit the planet, presents clear divisions in a number of important aspects. Spatially, it is divided into continents and nations with different demographic and geographical characteristics. There are differences in levels of development and wealth, as well as phenotypic and cultural differences, which include a diverse set of ethnicities. Many of these divisions are the result of adaptive, geographical and climatic processes, some are the result of eventual phenomena, and others derive from complex historical, social, economic and cultural processes. Some of these divisions, which could be merely differences (e.g. men and women) become inequalities, and very often iniquities, insofar as they define relationships that are essentially based on power and the access to, and the possession of, goods, services and wealth. Consequently, the fruit of collective work that has been accumulated over generations is often unequally distributed^{1,2}.

These inequalities are often transferred into the field of health: they are visible in the unequal health conditions of different groups, in the levels of health risks to which these groups are exposed, and also in terms of differential access to the resources available in the health system. It is no coincidence that most of the inequalities observed in the area of health are directly related to inequalities observed in other levels of social life³⁻⁵. Health inequalities generate unequal possibilities in relation to the ability to take advantage of scientific and technological advances in this area, different chances of exposure to the factors that determine health and disease, as well as different chances in relation to illness and death. In the same way that social inequalities have persisted in all countries, regardless of their level of development, health inequalities persist in the same fashion^{3,4}.

In the current international context, with nation states involved in the process of economic globalization, discussions about inequalities have highlighted inequalities within the same nation and also inequalities between nations. Inequalities between countries are related to the differences in economic and social development achieved by different countries, which are generated by the position that these countries have occupied during different phases of history with-

in the global productive system. The latter reflect historical aspects, and the international economic and political environment in relation to each country's share of global resources and development opportunities⁶.

Inequalities within a country relate to the distribution of accumulated wealth within a society, and in particular how that society is organized and the social relations and power established among its various strata. It is defined by the history and the political models that have been adopted, and how the state has redistributed national wealth through fiscal and transfer systems, which have generated greater or lesser distributive distances between existing social groups. Cultural elements are also important in terms of amplifying and consolidating some existing inequalities⁷.

More recently, the concept of global inequality has arisen, which involves the combined effects of these two types of inequalities⁸. Global inequality is the result of inequalities both between and within countries, and it is therefore defined by the interaction of the determinants of each. The availability of international data has made it possible to conduct empirical studies regarding the issue of global inequality. For example, when the GINI index, which is one of the most frequently used methods to measure social inequality within a country, is calculated globally it results in even higher levels than those found in nations with the highest levels of social inequality. In recent years, the GINI indices of countries with the highest levels of inequality have been around 0.60 (1 = maximum inequality and 0 = total equality), while the global GINI index is close to 0.70. The global GINI index captures the extremes of the poorest strata of the poorest countries and the richest strata of the richest countries, which translates into a higher level of inequality than when measured in each country separately.

The aim of this article is to present health inequalities as a global problem that affects the populations of poor countries, but also those of rich countries, and the continuation of these inequalities demonstrates the historical and structural roots of this problem. Although this discussion is related to discussions about poverty and health, it has a different, more specific dimension. Health inequalities are undoubtedly one of the most relevant problems in the field of population health and they represent a challenge to those who seek to overcome them.

Determinants of health conditions

For many, health is understood as being restricted to biological factors; for others, it is a complex phenomenon with multiple determinations that are based on the way people live and are organized. For a long period these two explanatory theories have formed the basis for discussions, and they have competed to provide plausible explanations about the health conditions of human populations⁹⁻¹¹. The relevance of this debate is that it defines the manner in which societies organize themselves to solve their health problems.

The former theory is based on the development of biomedical sciences and their explanations of the mechanisms of diseases, as well as alternatives to correct them. It focuses on the search for a detailed understanding of human biology in the expectation that this will provide the necessary explanations to understand how human health disorders occur and how they can be corrected. It supports technologies based on prevention, diagnosis, cure and rehabilitation, which are available or being developed, and forms the basis of what we now call a “modern” health system. The development of this system has been accelerated by advances in biomedicine and resulting technologies, especially since the second half of the twentieth century.

The latter theory precedes the development of biomedicine and argues that there is accumulated evidence that changes in economic, social, political, environmental, cultural or behavioral contexts affect the health conditions of individuals and populations¹¹⁻¹³. Conceptions about the social determination of health and disease developed during the nineteenth century and they were expressed in the works of important thinkers who were mainly located in Europe. These pioneers established the idea that the health conditions of populations are directly related to the context in which they live, and the position of individuals in the social pyramid. Of particular note are studies by Louis René Villermé¹⁴ in France, Edwin Chadwick¹⁵ in England and Rudolf Virchow¹⁶ in Germany, all of whom provided seminal contributions to the theme of social determination.

Because we live in an age when these two theories coexist, and biomedical sciences and health services are both growing and strengthening, it is evident that these theories are in competition with each other. Health services, as they are currently organized, play an important role in cur-

ing and rehabilitating many of the pathological processes that afflict individuals. For example, prevention actions such as the use of vaccines and screening methods for the early diagnosis and reduction of damage from pathological processes are already available. However, they have few resources to deal with the social and environmental determinants that are the source of many of the health problems affecting individuals and populations. With limited exceptions (vaccine-preventable diseases) there has been little action regarding the incidence of health events.

This dispute has fueled a prolonged debate regarding the importance of each of these theories in relation to the health conditions of human populations. The most elaborate contribution was by Thomas McKeown, who from 1950-1980 wrote an important body of scientific work which argued that medical technology and the health system played a secondary role in the important and positive changes that occurred in the health conditions of the English population from the late nineteenth century until the second half of the twentieth century^{17,18}. McKeown argued that these transformations could be explained by improvements in general living standards, especially in terms of diet and nutritional status, which were the result of better economic conditions. During this period great changes occurred in several spheres of life, especially in the economic, social, cultural and environmental fields, which were the main explanatory factors for the significant improvements in the population's health conditions. As in the case of England, health conditions in many countries which are now developed also had their greatest turning point, for the better, over the same period. For much of this period, most of the preventive, diagnostic or therapeutic resources for the diseases and health problems that exist today were not available. These technologies were only invented in the 1930s and they were only used in a large-scale in health systems from the 1940s¹⁹. This chronology is central to McKeown's thesis that the immense changes in health conditions observed in the late nineteenth and early twentieth centuries only minimally depended on biomedical technologies.

Although some of the arguments put forward by McKeown have not been fully confirmed, especially his emphasis on the role of diet and nutrition, his argument about the secondary role of biomedical technologies has had widespread repercussions^{10,20}. While health technologies have had been intensely developed over the last decades, and some of them highly effectively, argu-

ments about the importance of technologies and the health system transforming the health conditions of populations have not been empirically demonstrated. After the massive introduction of biomedical technologies and the expansion of health systems, this type of research has become subject to interpretative confusion. At the moment that the two effects (social determinants and biomedical technologies) became active there were clear methodological difficulties in separating the effect of each of them. However, reinforcing the thesis of social determination, in this same group of (developed) countries, despite the advances in systems and levels of health that have been observed, important differences persist in health conditions when their populations are stratified by geographic areas or social or ethnic groups⁵. In addition, periods of crisis are often accompanied by worsening health conditions in the populations of these countries. For example, events such as the disintegration of the former Soviet Union, or the financial crisis of 2008 which led many European countries to economic recession and the implementation of austerity policies, were followed by worsening health conditions for their respective populations²¹.

The study of historical trends in the health conditions of populations remains an important source of evidence for the social determination of health and disease, as well as health differentials between countries. A research program that originated in the economic and demographic sciences has shown a strong relationship between the economic development of countries and health²². Although it initially focused on economic factors, this line of research was modified to include the effects of different social factors and policies (education, public health, etc.).

Social determinants: inequalities and equity

As we have seen, since at least the nineteenth century evidence has increased that the health conditions of a population are related to the characteristics of its social and environmental context. Poverty, poor housing conditions, an inadequate urban environment, and unhealthy working conditions are factors that negatively affect the health conditions of a population. At the end of the nineteenth century, biomedical sciences emerged and began to have an overwhelming influence in providing explanations for health problems and diseases, with social and environmental determinants being secondary. However,

biomedical theories have never adequately explained many phenomena within a population (for example, the rich have better health conditions than the poor) or between populations in different countries (for example, richer countries have better health conditions than poorer countries).

With few exceptions, the occurrence of the most diverse diseases and health problems is aggravated for social groups living in socially disadvantaged situations, in other words, for the poorest, ethnic minority groups or groups that suffer any type of discrimination. It is not by chance that poor countries have worse health conditions compared to rich countries. Likewise, in any given country, whether rich or poor, the poorest regions and the poorest or marginalized ethnic groups consistently have worse health conditions. Further evidence is provided by the fact that when policies which improve economic conditions or strengthen social protection are implemented in any of these countries they have positive impacts on health conditions.

A recent and very important landmark that highlighted the persistence of health inequalities in developed countries was the so-called “Black Report” in the United Kingdom²³. In 1977, the Health Minister of a socialist government appointed a commission led by Douglas Black, who was then president of the Royal College of Physicians, to analyze the existence of health inequalities. This action was taken because the national health system in the UK (NHS), which had been created in the 1940s, was founded on the principles of fairness and universal accessibility. One of the relevant observations of this commission was that in the period since the establishment of the NHS there had been major improvements in the health conditions of the British population, regardless of social class (actually occupational class). But the most unexpected finding was that the differentials of health levels between social classes had persisted, and in relation to some problems they had actually widened. Furthermore, inequalities persisted regarding the availability and use of health services. These results were presented in 1979, when the British government was then led by the Conservative party, which not only resisted its publication but also made explicit its non-commitment to the results and recommendations in the prologue of the report. Nevertheless, this document had an immense impact on subsequent discussions regarding health inequalities in developed countries. In terms of academic research it rekindled interest

in research on inequalities in health, and in the field of politics it stimulated actions by governments regarding this dimension of inequalities. The report explained important moral issues experienced by these societies. It exposed a cruel aspect of capitalism, even at the advanced stages that it had reached in these countries, at a time when these societies would have been expected to be reasonably just in relation to their citizens.

At this point it is important to establish the differences between inequalities and inequities in health^{24,25}. Inequalities refer to perceived and measurable differences that exist in health conditions, or are related to differences in the access to prevention, cure or rehabilitation of health (inequalities in health care). Health inequities, on the other hand, refer to inequalities that are considered to be unjust or that stem from some form of injustice. It reflects on a society how it translates existing inequalities and differentiates them into just or unjust ones, and this translation varies among societies. In many societies, huge differentials in health levels between individuals at the top or bottom of the social pyramid are not perceived as being unjust. This can happen in developed, poor, or developing countries. Conversely, in other societies relatively small differences in health levels can be translated into a strong public perception of inequity. This happens, for example, in some Scandinavian countries. This issue is important because although inequalities are the subject of discussions in the scientific field and several methods have been developed to measure them, which facilitates comparative studies of health inequalities both within and between societies, it is more difficult to objectively measure inequities because they translate the way that societies perceive and interpret these inequalities, even though it is extremely important to understand them. The conditions for formulating concrete political actions aimed at minimizing existing inequalities emerge at the moment when inequalities become inequities.

In recent decades, the growth of the neoliberal perspective and individualism has strengthened the belief that events within society are the responsibility of the individuals who suffer them, minimizing the view of society as a social and collective phenomenon. This perception of the world has been the foundation for influential political forces to interpret inequalities as the fruit of individual problems and to deny that they are an expression of injustice, leading to the argument that there is therefore no need for government policies and actions to minimize them.

However, the issue of social inequalities in health has grown within intellectual and academic debates in recent decades around the world. The availability of data from a variety of sources has uncovered and provided new evidence regarding the extent of health inequalities and, furthermore, shown that in many contexts they are increasing. A few countries (especially in Europe) have used this evidence to introduce actions based on social determinants into their health policies and to partially reduce inequalities; however, the vast majority have not placed this issue among their political priorities.

At the international level, the importance of social determinants of health became more prominent at the time of the creation of the World Health Organization (WHO) Commission on Social Determinants of Health. This high-level commission was created by the Director-General of the WHO in 2005 with the mission to organize the evidence regarding the actions necessary to promote equity in health at the global level. In its final report, which was published in 2008 with the provocative title of “Closing the gap in a generation”²⁶, after a thorough analysis of the evidence of the importance of social inequalities in health in determining many health problems the Commission called on the WHO and all world governments to work towards reducing all forms of health inequalities²⁶. The Commission synthesized its recommendations into three central points: 1) to improve daily living conditions; 2) to combat the unequal distribution of power, money and resources; and 3) to measure the magnitude of the problem and evaluate the impact of actions. The Commission’s report was followed in 2011 by the 1st World Conference on the Social Determinants of Health, which was convened by the WHO and held in the city of Rio de Janeiro, Brazil with the participation of delegates from 125 different countries. The main output of the conference was the Rio Political Declaration on Social Determinants of Health, in which delegates affirmed their “determination to promote social equity and health through actions on the social determinants of health and well-being implemented through a broad intersectoral approach”²⁷.

Theories that seek to explain health inequalities

Studies about health inequality which start from different theoretical foundations in terms of their empirical investigations offer different

interpretations and solutions in relation to the problem. Although they have tended to focus primarily on explaining inequalities among social groups within the same nation, similar theoretical foundations can serve as a basis to interpret inequalities between nations and also global inequalities. To summarize, it is possible to state that these theories are organized into two types of explanations; one based on individuals and another based on structural explanations^{5,28}.

The explanations based on individuals are very popular among Anglo-Saxon authors; however, they are grouped into different tendencies and those that stand out are as follows: those that focus on the material dimensions of life, especially regarding the form in which the wealth of society is distributed among its members; those that focus on cultural-behavioral dimensions (lifestyles); and those that emphasize psychosocial dimensions, i.e. how individuals interpret their position in the social hierarchy and the links between this perception and subsequent biological phenomena (e.g. stress mechanisms), with their potential pathogenic effects. The psychosocial theory originated in the 1960s and 1970s through the works of John Cassel^{29,30}. However, another line of study, initiated by Richard Wilkinson, constituted a new and interesting evolution of the original theory^{31,32}. Wilkinson developed the idea that inequalities not only determine differences in the material world, and therefore explain pathologies related to various deficiencies (e.g. famine, poor housing or sanitation conditions, and insufficient income to cover the costs of rearing children), but that inequalities themselves generate complex psychosocial phenomena that are expressed in pathogenic phenomena, in other words, social inequalities have pathogenic properties. This concept was subsequently expanded to (partially) explain existing inequalities among other forms of stratification and discrimination, such as, for example, between genders and ethnicities³³.

The structural explanations focus on the idea that the social determinants which generate inequalities in health are shaped by determinants that exist within the superstructure of society, i.e. politics, productive organization, etc. The political definitions that organize the state will also result in political options that will either favor or reduce health inequalities. Reinforcing this theory, and providing contrary evidence to those who still believe in distributive possibilities and the consequent reduction of inequalities within the capitalist framework, recent empirical evidence

from a study by Piketty³⁴ shows that capitalist accumulation tends to be differential. It is greater between favoring those who have already accumulated, which results in the expansion of social inequalities. This tendency can be contained or mitigated by distributive policies, when they are eventually adopted.

New scenarios regarding social inequalities in health

In a world undergoing intense transformations, some social processes are amplified by the process of globalization and they grow in importance because of their implications for health inequalities. Due to their current relevance and their implications in relation to health inequalities, the following two aspects will be now be highlighted: urbanization and migration.

Urbanization and the importance of cities

In 2014, 54% of the world population lived in urban areas. In 1950, this percentage was only 30% and it is estimated that in 2050 this percentage will exceed 70%. The highest rates of urbanization are in North America (82% of the population) and the lowest are in Africa (40% of the population). Latin America and the Caribbean have high urbanization rates, with 80% of their population concentrated in urban areas, rates that are close to that of North America³⁵.

This intense growth in urbanization was due to the massive transfer of the rural population to urban areas. The definition of urban can range from agglomerations with a few thousand inhabitants to megacities with several million inhabitants. In relatively restricted areas these centers group together a large number of people. These agglomerations create a series of problems and challenges which have repercussions in the health sphere; there tends to be an unequal and unfair distribution of space between social groups.

The patterns of inequalities that already exist in societies are reflected within these restricted spaces and it is possible to clearly see the ills that are generated by social inequalities and their deleterious effects on human health. In the nineteenth century, Villermé showed how the social and environmental differences between different neighborhoods in Paris were reflected in unequal mortality rates¹⁴ and these inequalities, although on a smaller scale and with less visibility, persist to the present day³⁶. In many poor and developing countries with high levels of social inequal-

ities, urbanization becomes synonymous with inequality and exclusion in all its forms.

Migrations and the limits of human movements

Since time immemorial, sectors of populations or even whole populations have moved to new destinations for various reasons. In 2013, it was estimated that 232 million people - 3.2% of the world's population - lived outside their country of birth, and another 700 million were internal migrants in their own country of birth³⁵. The patterns and motives for these migratory movements have changed greatly over time; however, it is clear that the majority of migrants who cross national borders do so in search of better economic and social opportunities. In recent decades, exacerbated disparities between nations, global economic expansion, geopolitical transformations, wars, ecological disasters and many other occurrences have had, and will continue to have, a profound impact on people's decisions to move to other nations. The recent phenomenon of the massive migration from some Arab countries to Europe is an example of the explosive and uncontrolled possibilities that the migratory issue can generate (<https://www.socialeurope.eu/focus/europes-refugee-crisis/>).

The migratory issue introduces an important point into the debate on inequalities. Estimates show that social inequalities between countries account for a larger share of global inequalities than inequalities within countries. While inequalities within nations are much more related to class issues and other processes of social stratification, inequality between nations raises the issue of place of birth, or what has been termed the "citizenship prize", which is related to history and the overall process of development of nations^{6,7}. Returning to the question of life expectancy mentioned above, a child born in Sierra Leone in 1990 only had an average life expectancy of 38 years, which was less than a child born in Japan in the same year (46 years compared with 84 years). Therefore, the issue of where one is born takes on great importance, and the migratory movement is defined by this attempt to change what was to some extent established by one's place and moment of birth. However, in a globalized world, in which capital, commodities and human beings circulate, there are serious limitations on the movement of people, especially when they wish to move between nations.

Global health conditions: the expansion of inequalities

At the global level, indicators of the health conditions of populations generally show positive trends. However, more detailed observations of the existing evidence demonstrate that this picture is much more dynamic, with the persistence of health problems or diseases that should have been eradicated or controlled and the emergence of unexpected health problems or diseases. In fact, inequalities in the level of health persist and, in many cases, have increased between nations or between regions and social or ethnic groups within the same nation.

A brief summary of inequalities between nations

An estimated 800 million people worldwide are chronically hungry. One in six children in developing countries is underweight, and more than one-third of deaths among children under five are attributable to malnutrition³⁷. Insufficient access to safe and nutritious food exists despite the fact that global food production is sufficient to cover 120% of global dietary needs.

Life expectancy at birth is an important marker of health conditions and the chances of survival for a population. On the global average, the life expectancy at birth of an individual in 1990 was 64 years; in 2013 that number had increased by seven years to 71 years. However, as averages these values conceal a series of inequalities. For example, in 2013 the average life expectancy at birth in countries ranged from a minimum of 46 years (38 in 1990) in Sierra Leone, to 84 (79 in 1990) in Japan. By 2013, life expectancy had increased in both countries and although the gap has narrowed slightly (from 41 to 38 years) they are still at unacceptable levels³⁸.

Children are especially sensitive to social and environmental adversities. Despite advances in recent decades, it is estimated that 6.3 million children under the age of five died in 2013, mostly due to preventable causes in poor or developing countries. Children in sub-Saharan Africa are 15 times more likely to die before their fifth birthday than children in the world's developed regions. In 2015, the highest mortality rate was observed in Afghanistan (115 deaths per 1,000 live births) and the lowest was in Monaco (1.8 deaths per 1,000 live births)³⁹. From 1990, when the Millennium Development Goals were established, to 2015 the global infant mortality rate fell

from 62 to 32 deaths per 1,000 live births. Despite this substantial reduction (around 50%) the established target was not reached, which was to reduce the 1990 rate by two-thirds.

Today, infectious diseases continue to be the leading cause of death for children and they are also a major cause of death in adults. Globally, three of the top ten causes of death are infectious diseases. These also account for 16% of deaths each year. Most of these deaths occur in poor and developing countries and they are attributable to preventable or treatable diseases such as diarrhea, respiratory infections, HIV/AIDS, tuberculosis and malaria. Although there have been significant advances in interventions to prevent and treat most of these diseases, such interventions are not always available for the populations that need them. Taking the example of tuberculosis, which is a disease highly linked to the conditions in which afflicted populations live and whose occurrence changes rapidly when these conditions change, in 2013 it was estimated that nine million people became sick with tuberculosis worldwide, with most of these cases (56%) occurring in Southeast Asia and the Western Pacific. However, Africa had the highest incidence of tuberculosis, with 280 cases per 100,000 inhabitants. Of these cases, around 500,000 were caused by multi-drug resistant tuberculosis (MDR-TB) bacilli, which, in addition to causing more severe diseases, often increase treatment costs, making them prohibitive for the majority of patients living in poverty. In the same year, the estimated total number of deaths from tuberculosis was 1.5 million. Of these deaths, more than 95% occurred in developing countries, although the death rate fell by 45% between 1990 and 2013⁴⁰.

Non-communicable chronic diseases (NCDs) as a whole are responsible for a significant proportion of the world's burden of diseases, accounting for almost two-thirds of global deaths (36 of the 57 million deaths in 2008). The main health problems in this group are cardiovascular diseases, cancers, chronic respiratory diseases (such as COPD and asthma) and diabetes. Although other diseases, such as mental and neurological diseases (including various forms of dementia), contribute to the high burden of morbidity (lower mortality), they have not been prioritized in global plans. NCDs are increasing rapidly in developing countries, where they impose large-scale human, social and economic costs, many of which could be avoided with well-known, cost-effective and feasible interventions. Although they were initially associated with

wealth, evidence shows that about 80% of NCD deaths occur in developing countries. Even in sub-Saharan nations, where communicable diseases, maternal and perinatal issues, and nutritional deficiencies are still more important when taken together, they are in decline, whereas cases of NCDs are growing rapidly. This picture has resulted in projections that by 2030 NCDs will be the most frequent cause of death on the African continent⁴¹.

It is estimated that more than five million (9%) of deaths occurring globally are related to various forms of violence. Approximately a quarter of these deaths result from suicide and homicide, and traffic accidents are responsible for another quarter. The various types of violence vary in different regions of the world, but, in general, their rates are always higher in poor and developing countries⁴².

The growth in health inequalities: possible solutions

The construction of a more equitable world has been the aspiration of different political movements which understand that reducing inequalities in the various spheres of human life is essential and guarantees the existence and sustainability of human society. Health inequalities expose one of the facets of inequalities that are prevalent among human beings, the cruel and damaging effects on one's own existence, which is reflected in the immense differences in life expectancy or the burden of disease and suffering.

The evidence of the importance of social determinants in explaining health inequalities is compelling. However, although there are clear academic and political arguments that favor the implementation of actions to redress the determinants of health inequalities, policies to mitigate these inequalities have been scarcely implemented as part of the public policies of national governments, and still less to alleviate inequalities between nations. There are several reasons for this lack of political motivation; however, some aspects have been recurrent in the literature regarding health inequalities.

One of the first aspects to consider is the consolidation of a health system based on biomedical knowledge and the resulting technologies, together with strong industrial and service sectors. These forces tend to generate and consolidate health systems that are only slightly affected in conceptual and structural terms, or favor actions directed at the social determinants of health.

The conceptual, moral, and political differences that exist in relation to the inequalities between social groups within the same nation and the inequalities between different nations have to be considered. The former is more often understood as being iniquitous than the latter. For example, this is explicit in the work of the influential moral philosopher John Rawls. In *The Theory of Justice*⁴² Rawls establishes the principles of justice that should be established between individuals and groups within the same society; he does not consider this relevant when the question refers to inequalities between nations⁴³. With regard to social inequalities in health, something similar also occurs. The research and literature on health inequalities predominantly focuses on inequalities between social groups within the same nation. Comparisons between nations (or other types of territorial organizations) have been relevant in some research, such as that developed by Wilkinson, which demonstrates the centrality of the levels of social inequalities of countries in relation to the health conditions of their populations^{31,32}. However, some scholars continue to argue that social inequalities in health are restricted to groups of individuals within the same society⁵. These scholars claim that the research program established by Wilkinson and others is “social ecology” rather than relating to health inequalities.

Another aspect is that interventions regarding the social determinants of health require coordinated action in relation to various aspects of the life of societies, which in governmental terms implies multisectoral actions. The latter, even when they are desired, are always difficult to coordinate and implement from the political and technical points of view. Nevertheless, efforts to overcome this issue have been forthcoming. The most advanced initiative to overcome this dilemma has emerged in some European countries, where the most recent action in the field of health inequalities has been the creation and implementation of the concept of “health in all policies”⁴⁴. This strategy aims to include health considerations in the formulation of policies in different sectors such as labor, agriculture and land use, housing, public safety, education, transportation, social protection, etc.

In the wake of the repercussions of the “Black Report”²³ and other important studies that have followed, some developed (mainly European) countries have experimented with coordinated government actions in the field of health inequalities²⁵. All these countries have information

systems and analysts capable of interpreting existing levels of health inequalities, but only a few, generally among those with the lowest levels of inequalities, have implemented policies focused on reducing health inequalities. This observation draws attention to the important discussion involving inequalities and inequities. The existence of inequalities, and their magnitude, does not immediately result in moral imperatives or generate political actions within a society. In some societies, relatively small levels of health inequalities have generated strong policy actions to reduce them (e.g. some Scandinavian countries), while others, with broad levels of health inequality, are not motivated to alleviate them (e.g. some Latin American countries).

In poor and developing countries, where health inequalities are of the highest magnitude, there are few examples of the latter being among the priorities of public policy. For example, following the establishment by the WHO of its Commission on Social Determinants of Health, Brazil, which is a country with immense social and health inequalities, created its own national commission⁴⁵. However, after two years of work this commission produced a report which, in the main, was not assimilated into government actions⁴⁶. Nevertheless, over the last two decades the implementation in many developing countries of redistributive policies such as income-transfer and micro-credits⁴⁷, which are non-health policies, have had positive effects on health inequalities⁴⁸.

With regard to inequalities between countries, the proposals and actions have been even more timid. For example, the final report of the WHO Commission on Social Determinants of Health²⁶ places great emphasis on inequalities within a particular society and less on inequalities between nations. It has a chapter dedicated to the issue of health inequalities in the global sense, which focuses on the need to strengthen so-called “global governance” and explains the need for coordination among various intergovernmental agencies. Some of these ideas were subsequently deployed in actions, such as the Millennium Development Goals (MDGs), which focused on the eradication of extreme poverty from 2000-2015 and their successor, the Sustainable Development Goals (SDGs), which include the additional aspiration of sustainable development in its three forms (economic, social and environmental) during the period 2016-2030.

More recently, another group (The Lancet, University of Oslo Commission on Global Gov-

ernance for Health)⁴⁹ has made advances in understanding and proposing actions in relation to global inequalities. The latest document produced by this group entitled “The Political Origins of Health Inequity: prospects for change” is intended to *convey a strong message to the international community and to all actors who influence global governance processes: we must no longer simply consider health to be a biomedical, technical issue; we recognize the need for multi-sectoral and global actions and justice to address health inequalities*⁴⁹.

In conclusion, although interest in the issue of health inequalities has increased from the academic point of view, this interest has only had a limited impact on public policies aimed at

improving the health of populations. Social inequalities in health are a global problem that, to a greater or lesser extent, affects all human societies. They are mainly due to the inequalities that exist between the different social groups in each society. Although the inequalities that exist between different societies and nations are relevant, and are often of a greater magnitude, they are not always considered to be unjust, and as such they are subject to political actions. The most plausible theory that has been put forward to solve the latter type of inequalities has been to improve the mechanisms of global governance, insofar as this includes an understanding of how nations were historically founded and the effect of the position of each country in the global productive system⁶.

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