

Desigualdades Internacionais em Saúde: Situações e Desafios

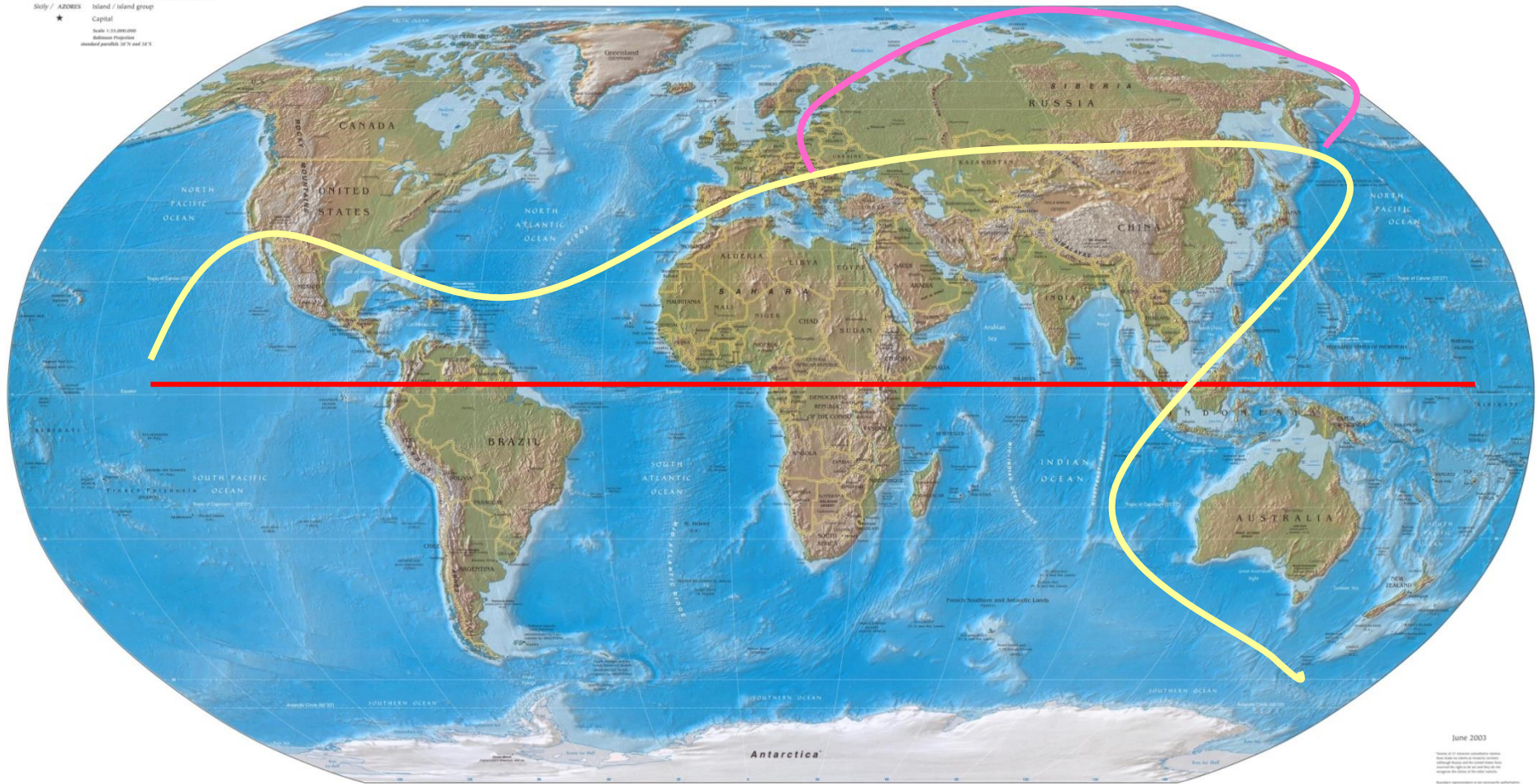
Mauricio L. Barreto

**Ciclo de Debates sobre Bioética, Diplomacia
e Saúde Pública – NETHIS-DIREB
Brasília, 19 de Maio de 2016**

The world, its North and its South

Physical Map of the World, June 2003

AUSTRALIA Independent state
Bermuda Dependency or area of special sovereignty
★ AZORES City / island group
★ Capital
Scale: 1:25,000,000
Reference: Projections
standard parallels 30° N and 30° S



June 2003

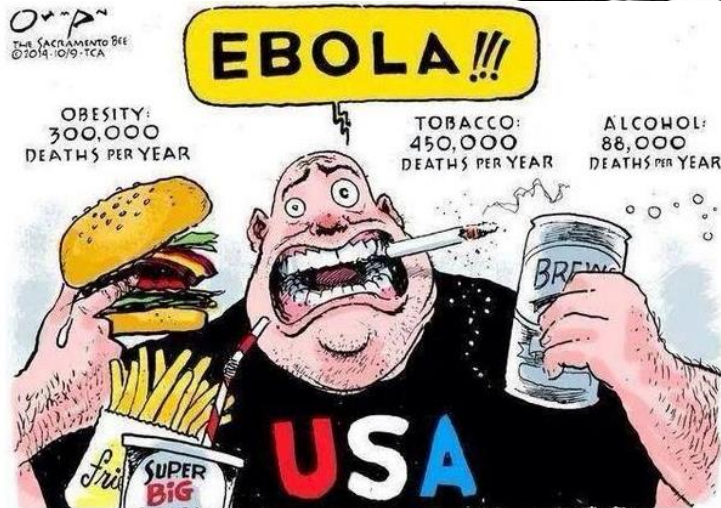
Scale of 1:25,000,000
Reference: Projections
standard parallels 30° N and 30° S

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Determinantes das Condições de Saúde e Percepção de Risco por Indivíduos e Sociedade



Figure 2. Formal definitions for risk, uncertainty, ambiguity and ignorance



Knowledge about likelihoods	Knowledge about outcomes	
	Outcomes well defined	Outcomes poorly defined
Some basis for probabilities	Risk	Ambiguity
	Incertitude	
No basis for probabilities	Uncertainty	Ignorance

Alguns Conceitos Básicos

- **[1] Determinantes das Condições de Saúde**
- **[2] A Constituição da Evidência a Elaboração de Políticas e Ações sobre a Saúde**

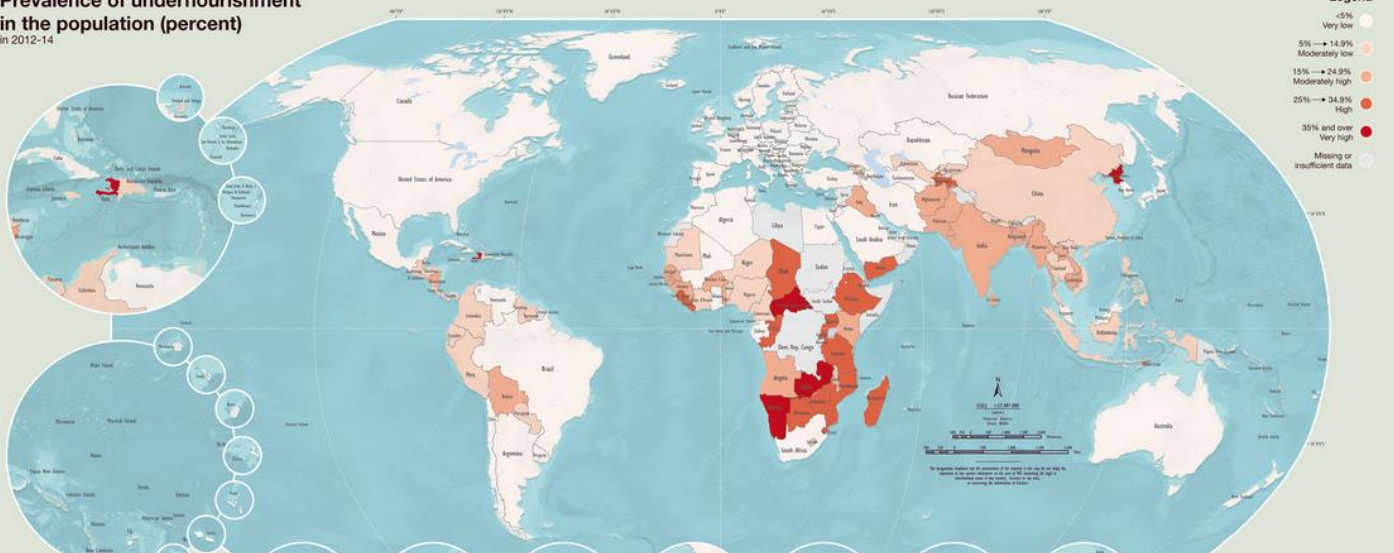
Alguns Conceitos Básicos

- **[3] Desigualdade versus Pobreza**
- **[4] Medindo as desigualdades: absoluto versus relativo**
- **[5] Desigualdades vs. Iniquidades em Saúde: do local ao global**

As condições de saúde - situação atual e tendências

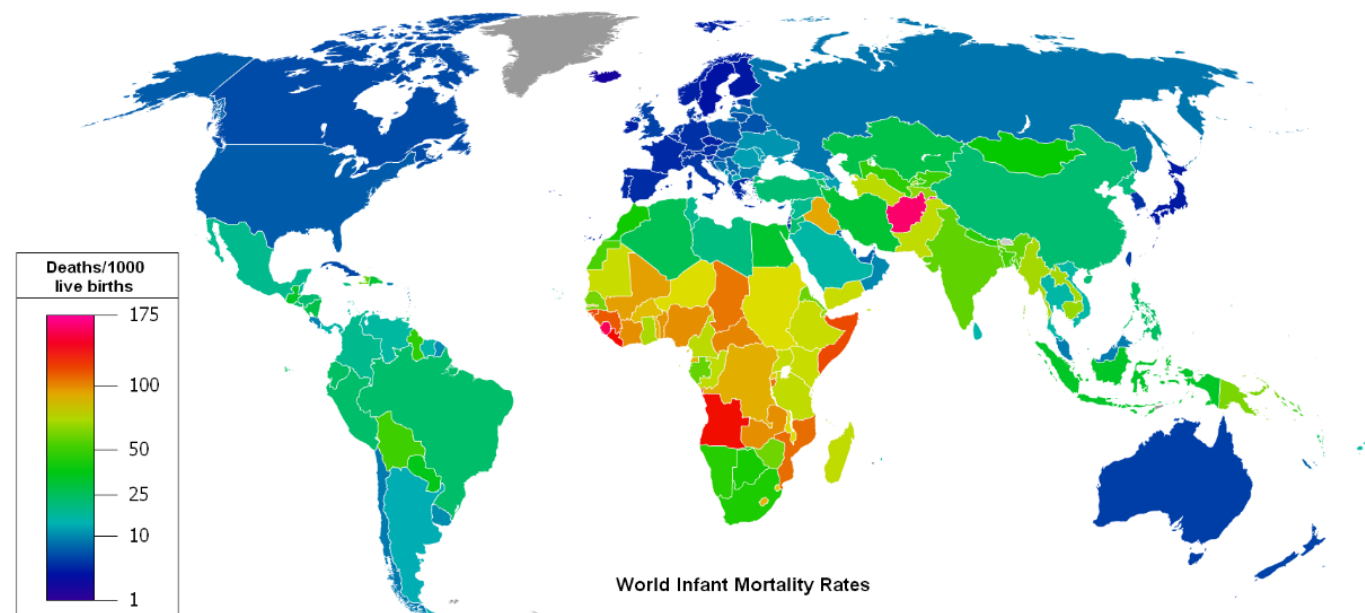
- A Fome e a desnutrição
- A mortalidade infantil e a expectativa de vida
- As doenças infecciosas
- A doenças crônicas e a epidemia de obesidade
- As diversas formas de violência

**Prevalence of undernourishment
in the population (percent)
in 2012-14**

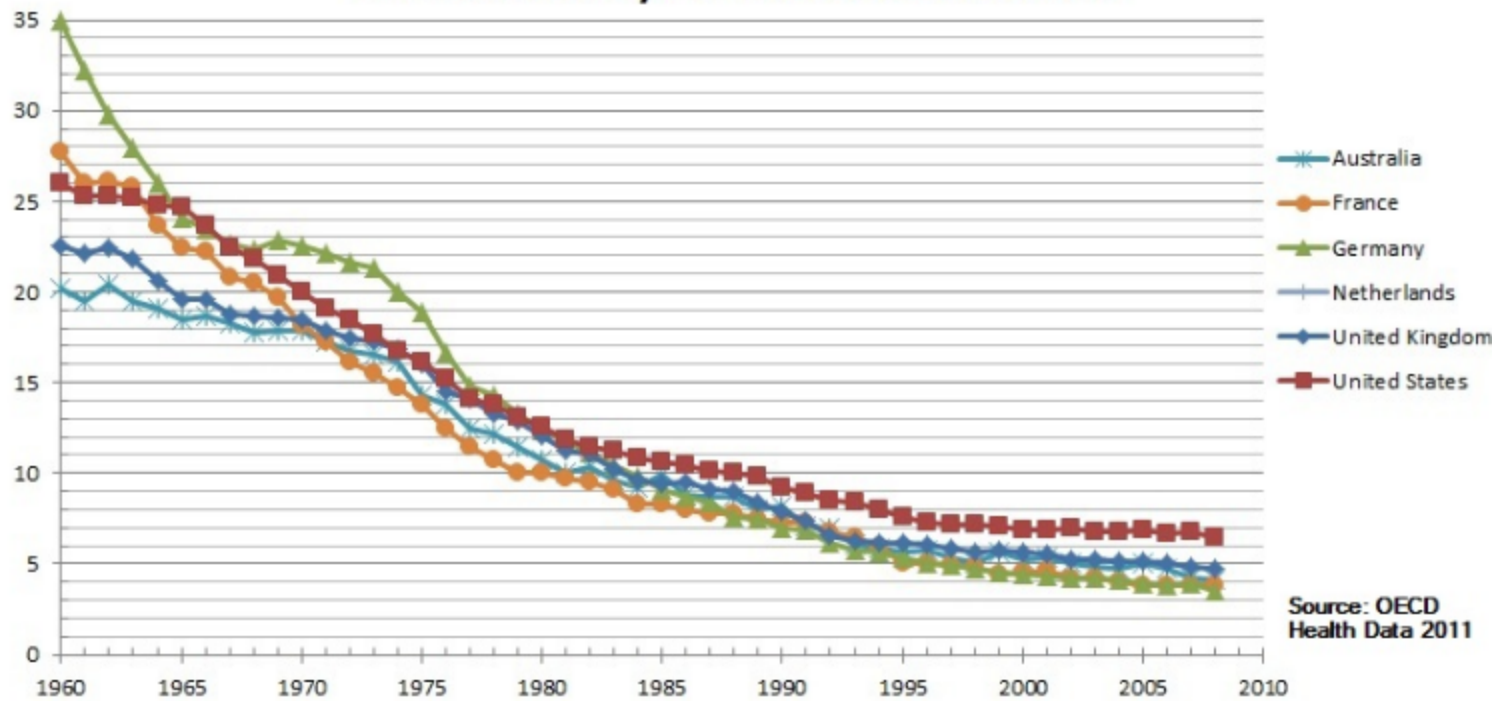


FAO
HUNGER
MAP 2014

Infant Mortality Rates



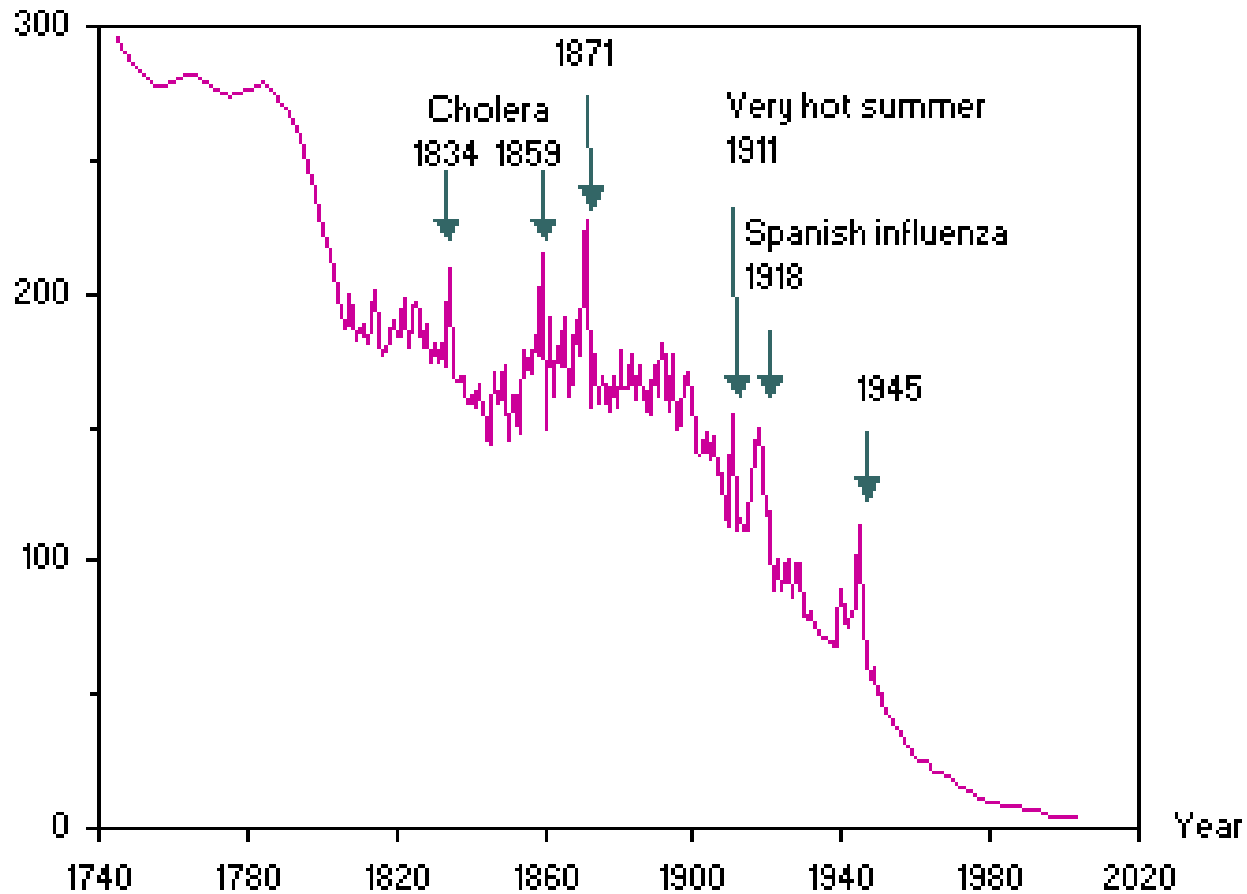
Infant Mortality Per Thousand Live Births



Source: OECD
Health Data 2011

Infant mortality in France : 1740-2004

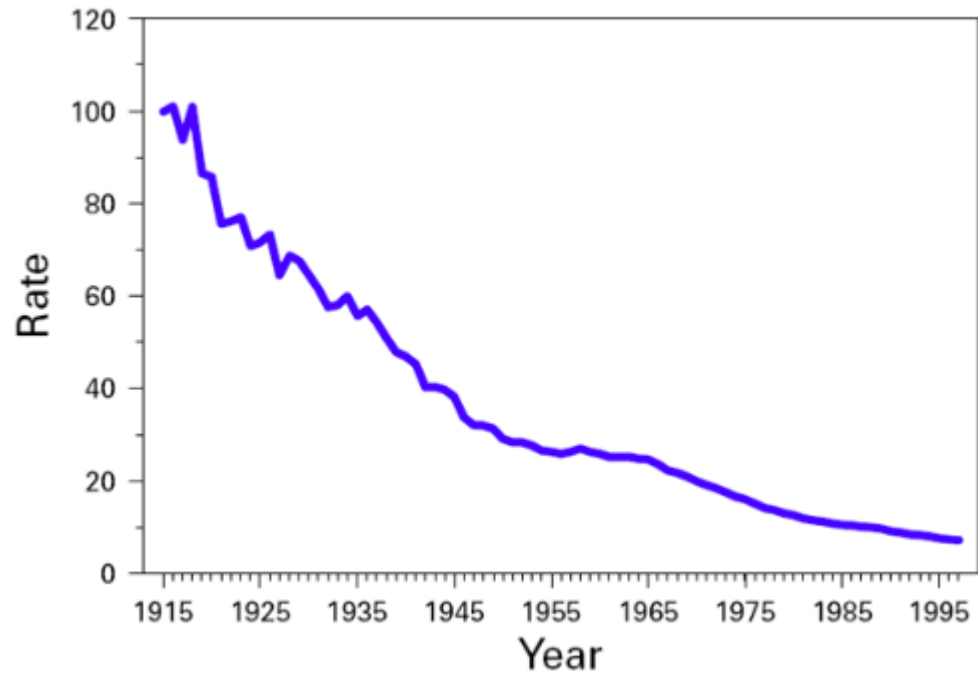
Risk of a newborn dying before his/her first birthday
(per 1,000 live births)



Source : Gilles Pison, *Population and Societies* n°410, Ined, march 2005

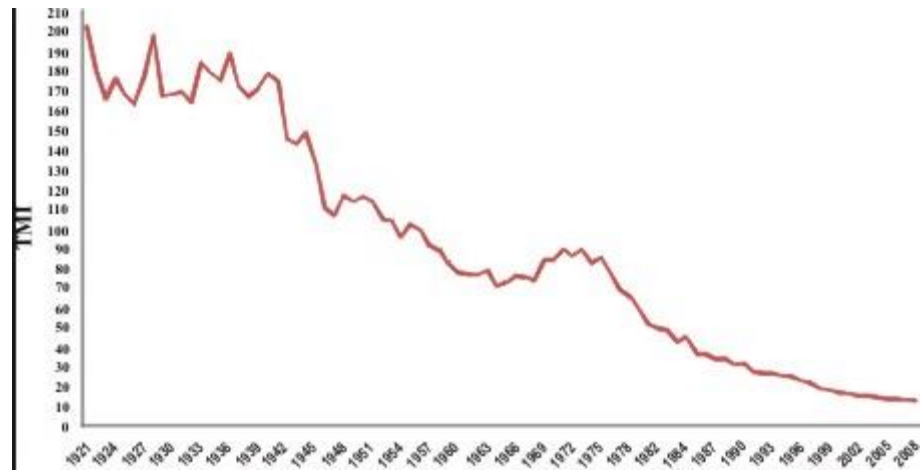
Teaching Kit, Ined (www.ined.fr)

FIGURE 1. Infant mortality rate,* by year — United States, 1915–1997

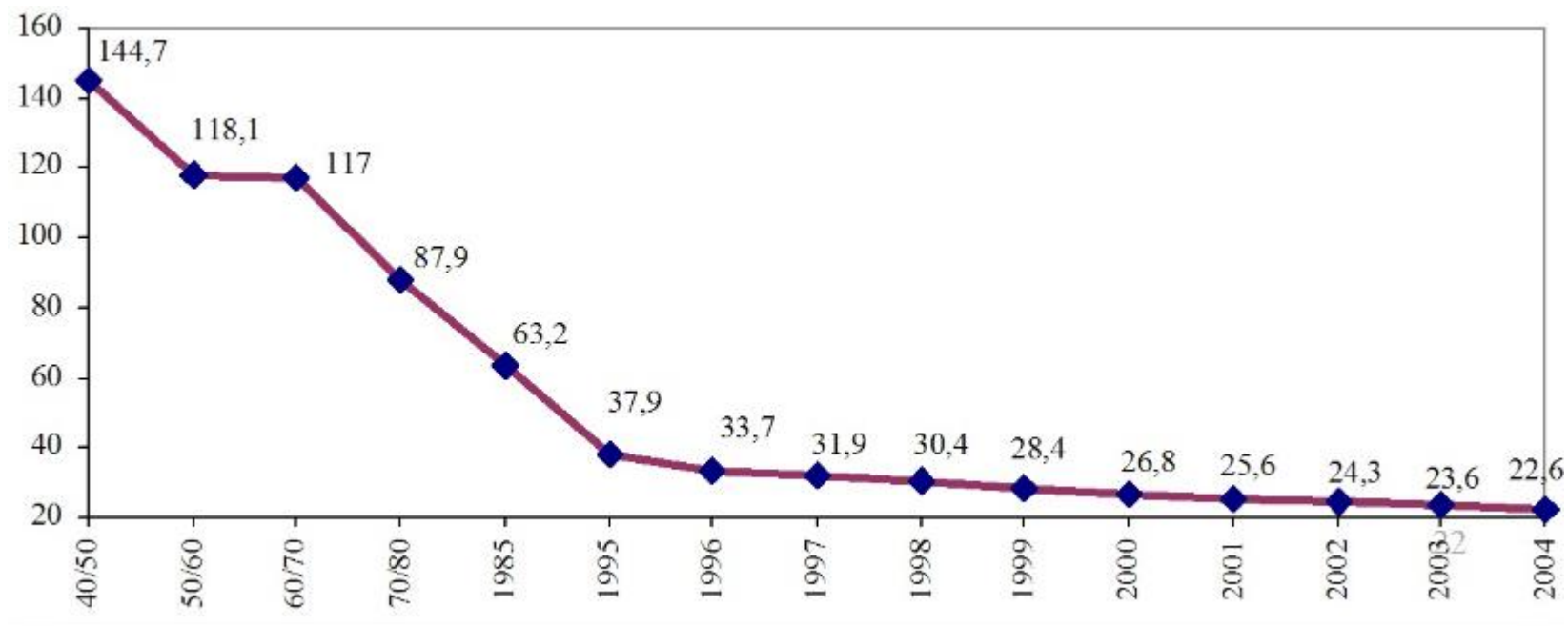


*Per 1000 live births.

São Paulo



Brasil



Tendência temporal na mortalidade infantil, Brasil, 1930-2006

Série Lancet Brasil

Taxas anuais de redução

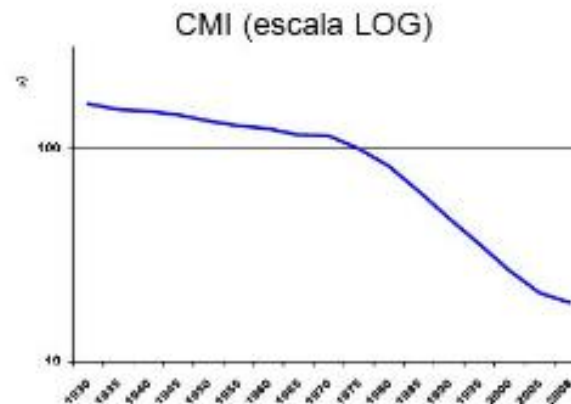
1930-70 \approx 1%

1970-79 = 3,2%

1980-89 = 5,5%

1990-99 = 5,5%

2000-06 = 4,4%



Source: Demographic Census, 1940-2000, and MEC (Ministry of Health) 1993-1998

Life Expectancy at Birth

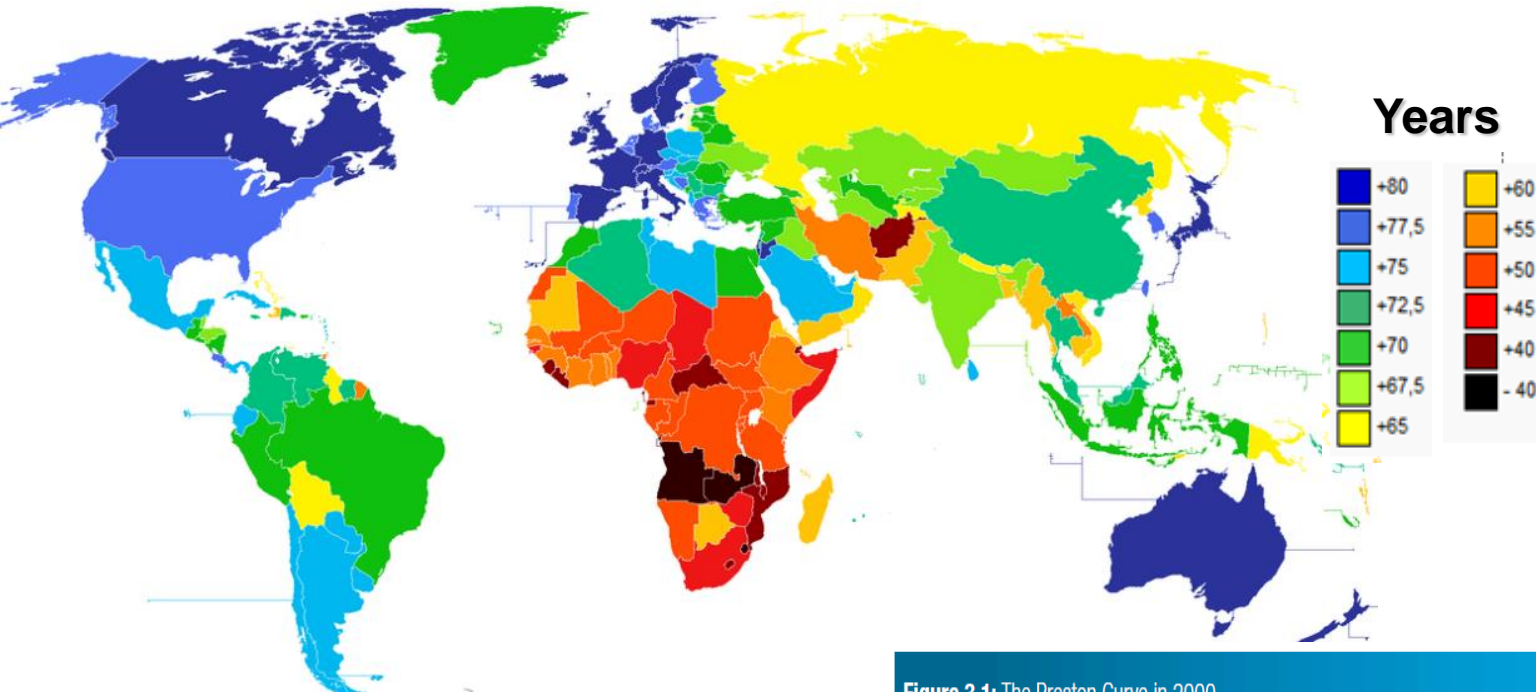
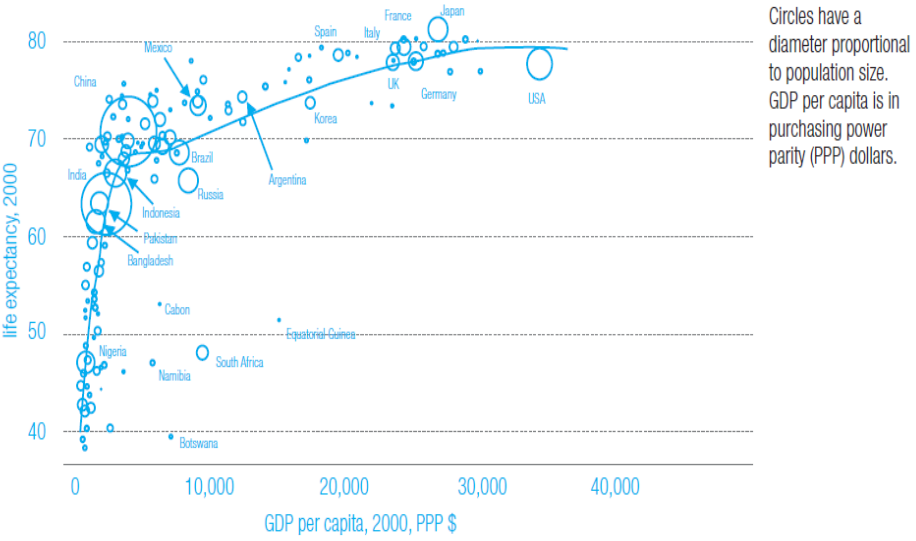
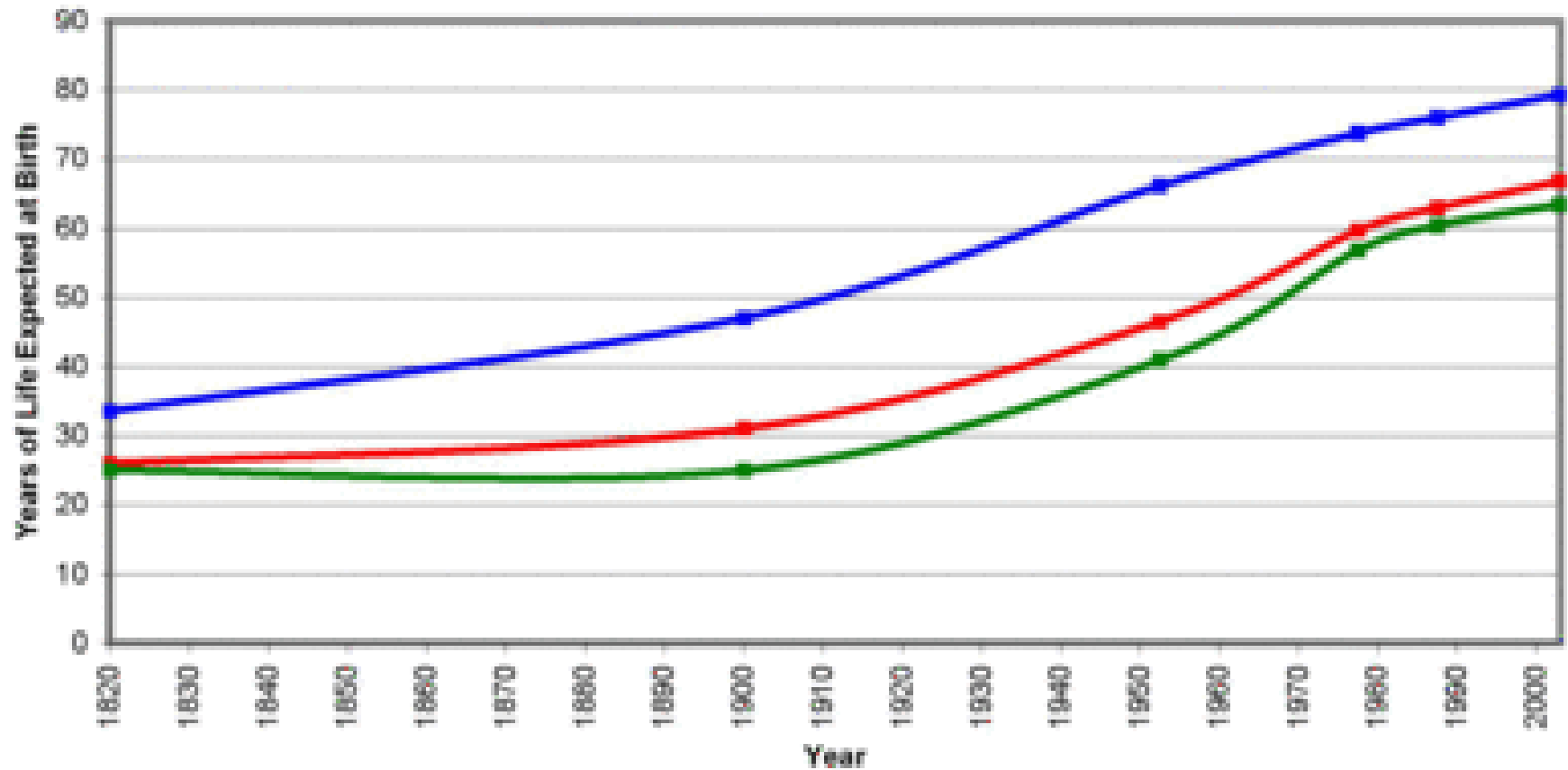


Figure 3.1: The Preston Curve in 2000.



Life Expectancy, 1820-2003

Global Developed Nations Developing Nations



Source: Indur M. Gokhale, "The Improving State of our World," Washington, DC: Cato Institute, 2007, 38. France used as a proxy for Developed Nations 1900 and earlier.

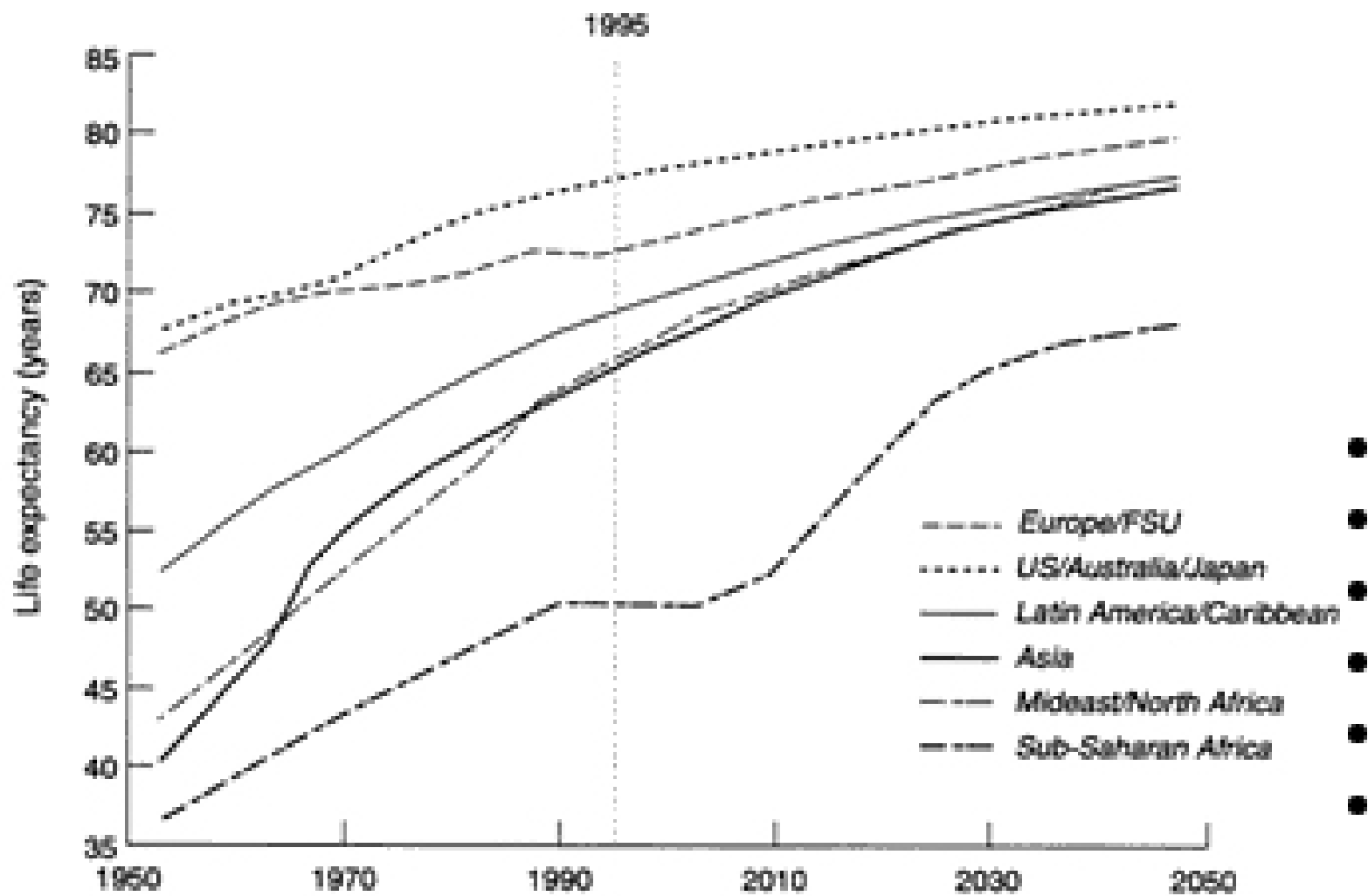
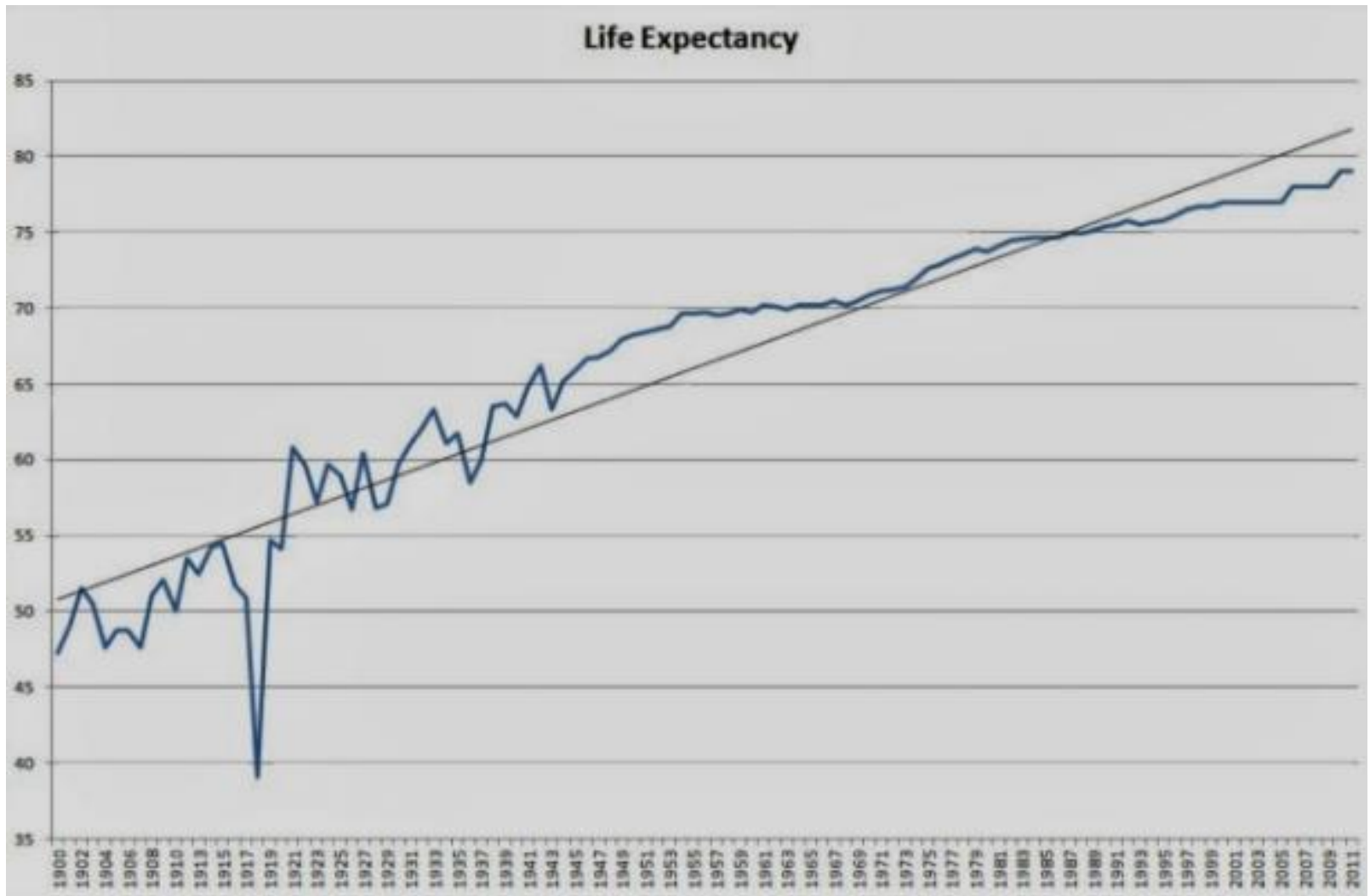
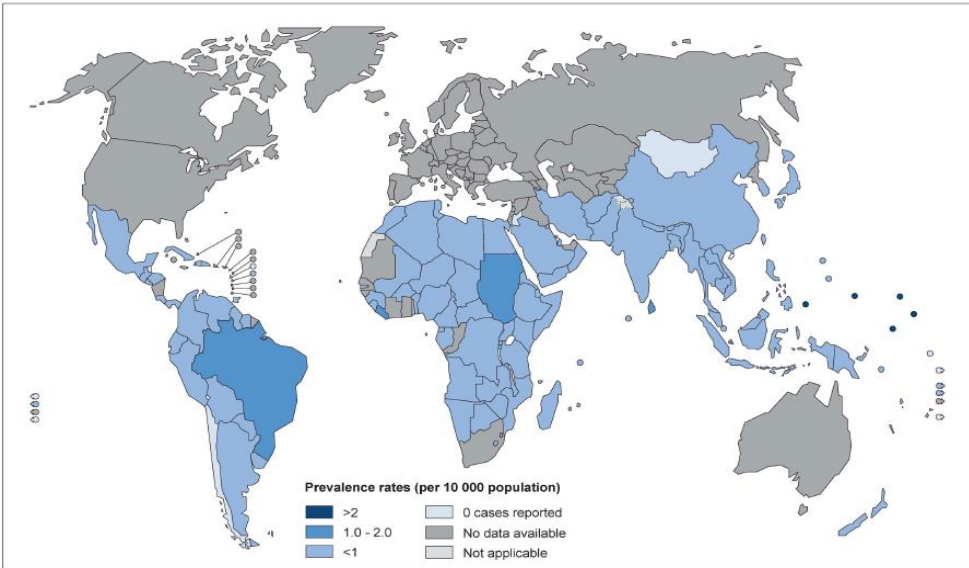


FIGURE 5-1 Estimated and projected life expectancy by region, 1950-2050.
 SOURCE: Data from United Nations (1999).

US



Leprosy prevalence rates, data reported to WHO as of beginning January 2011

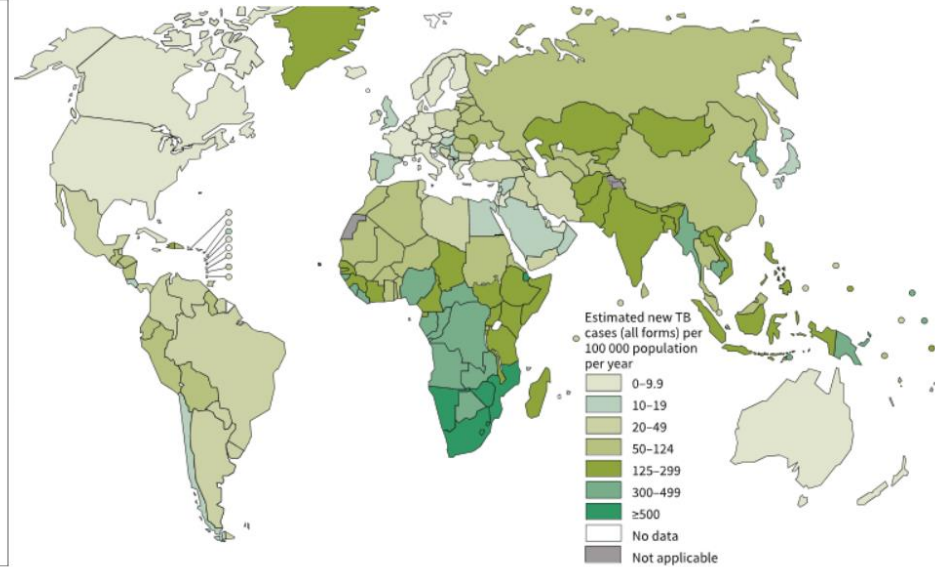


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Data Source: World Health Organization
Map Production: Control of Neglected Tropical Diseases (NTD)
World Health Organization



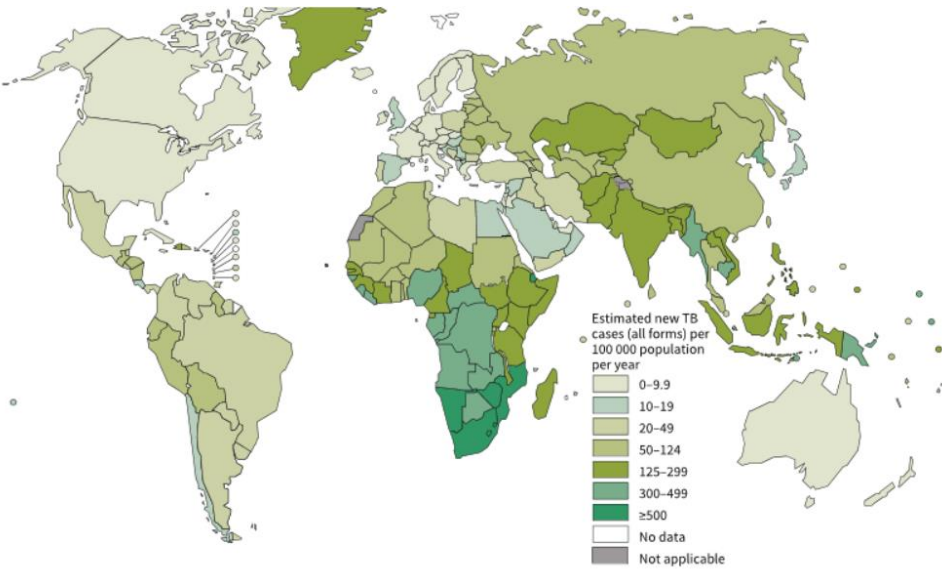
Estimated TB incidence rates, 2013



Dengue Transmission



Infectious Diseases



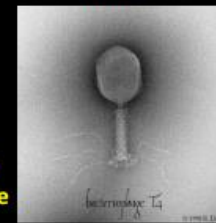
The 17 Neglected Tropical Diseases prioritized by WHO affect over 1 billion and are endemic 149 countries

Protozoa



Chagas disease
Trypanosomiasis
Leishmaniasis

Virus



Rabies
Dengue

Helminth



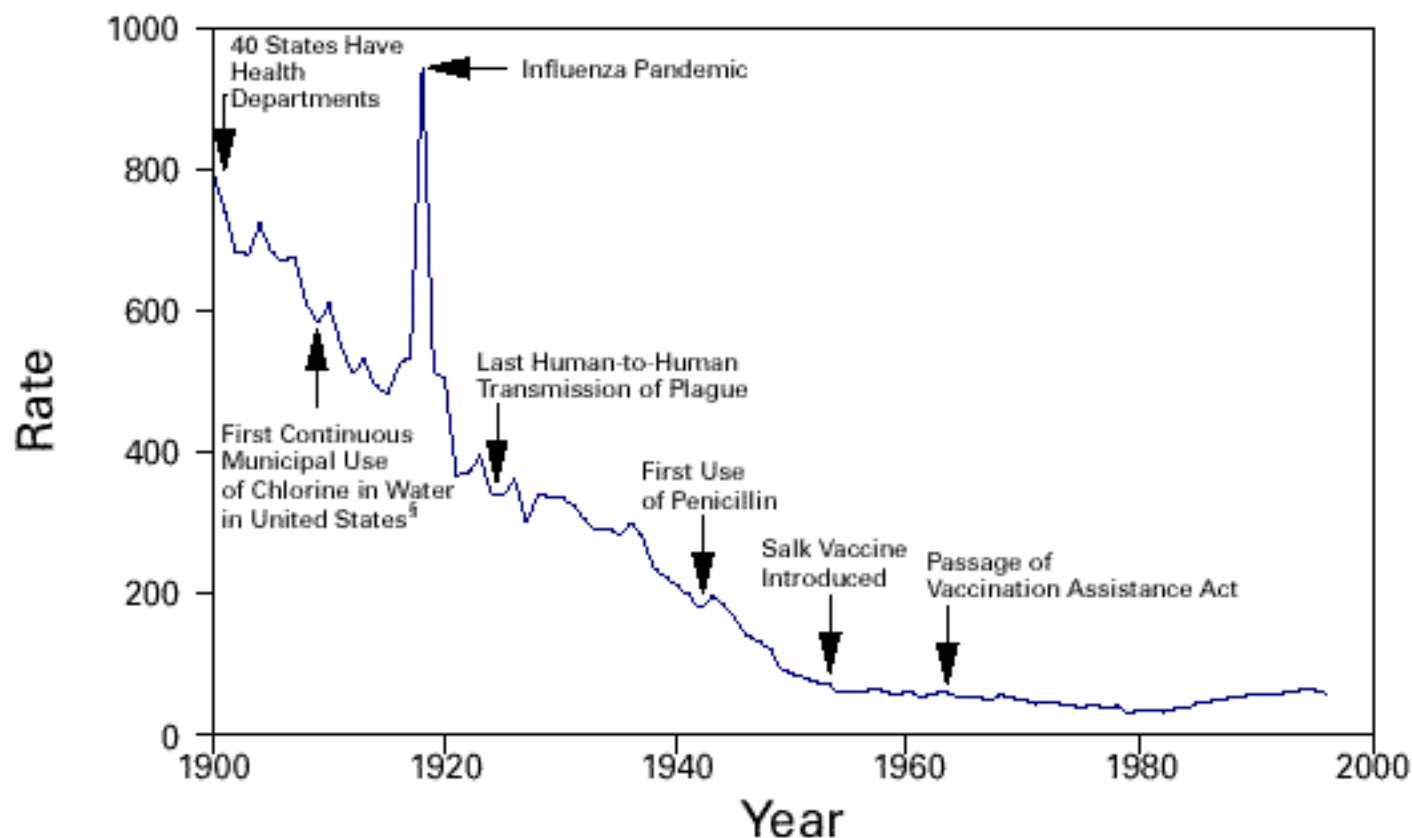
Cysticercosis/Taeniasis
Dracunculiasis (guinea worm disease)
Echinococcosis
Trematodiasis
Lymphatic filariasis
Onchocerciasis (River-blindness)
Schistosomiasis
Soil-transmitted helminthiasis

Bacteria



Buruli ulcer
Leprosy
Trachoma
Yaws

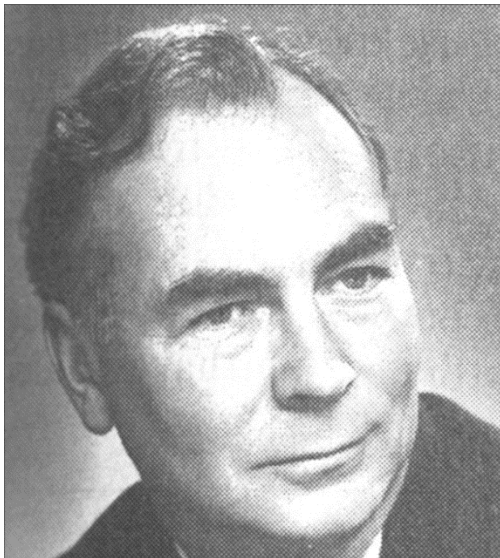
FIGURE 1. Crude death rate* for infectious diseases — United States, 1900–1996[†]



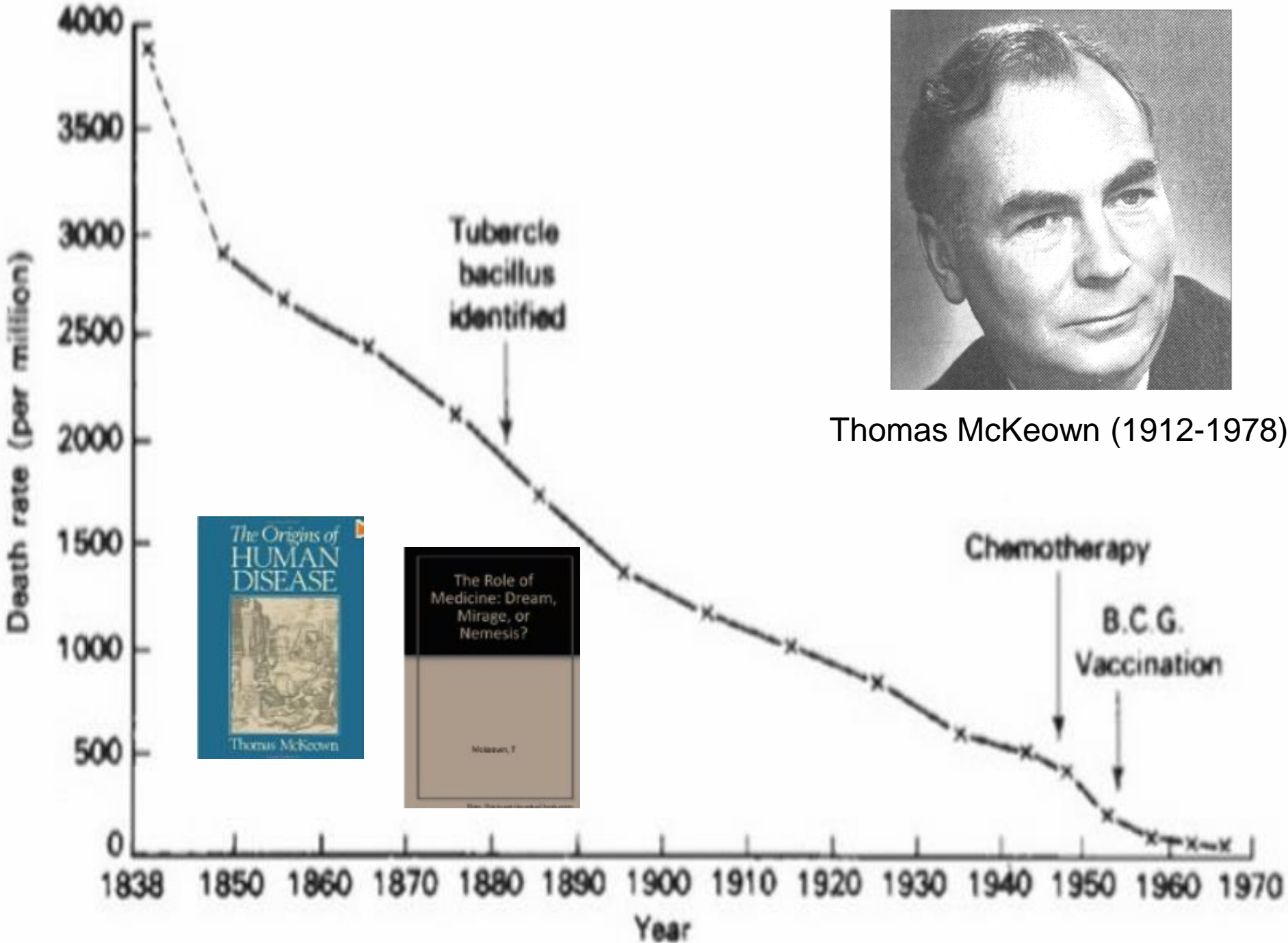
*Per 100,000 population per year.

[†]Adapted from Armstrong GL, Conn LA, Pinner RW. Trends in infectious disease mortality in the United States during the 20th century. *JAMA* 1999;281:61–6.

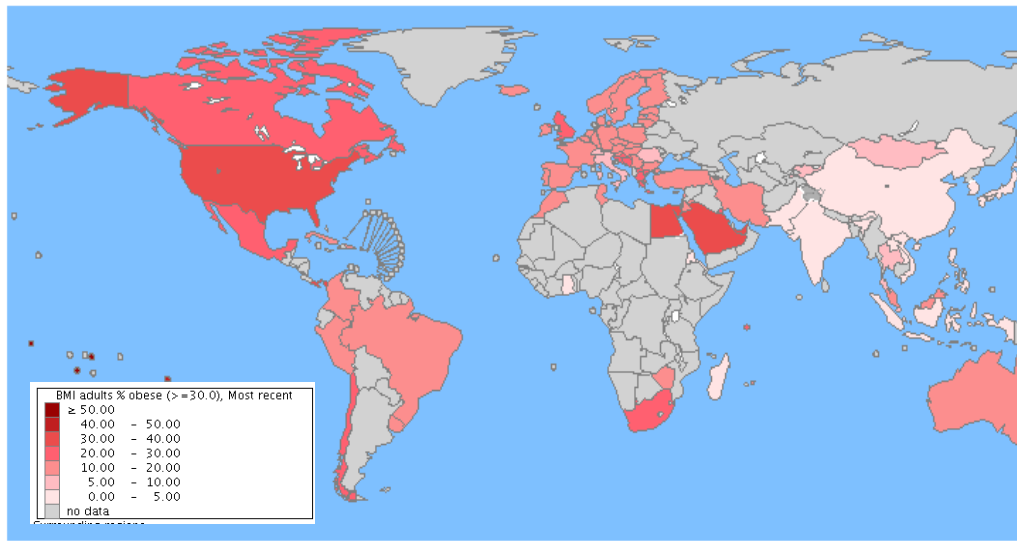
[‡]American Water Works Association. Water chlorination principles and practices: AWWA manual M20. Denver, Colorado: American Water Works Association, 1973.



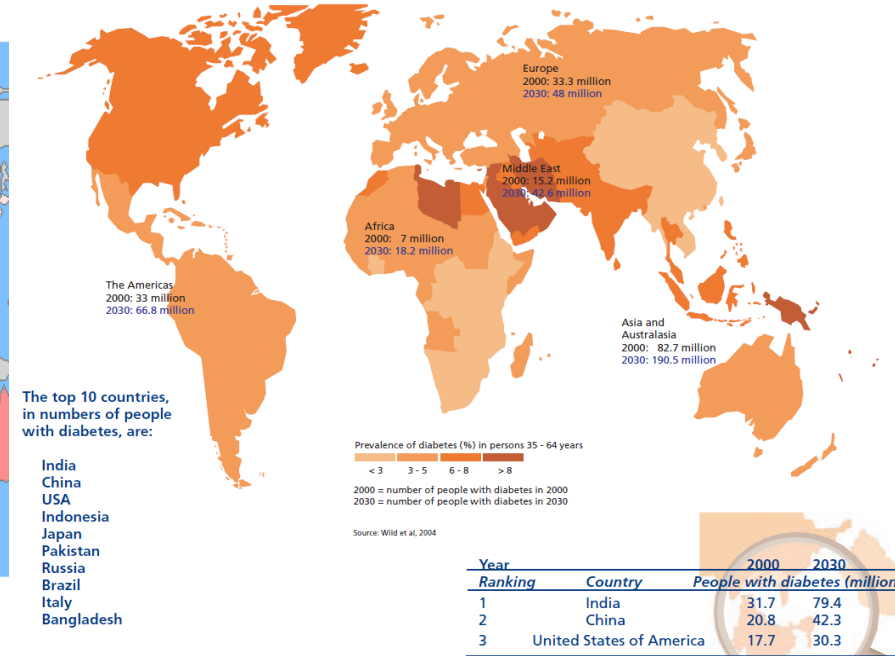
Thomas McKeown (1912-1978)



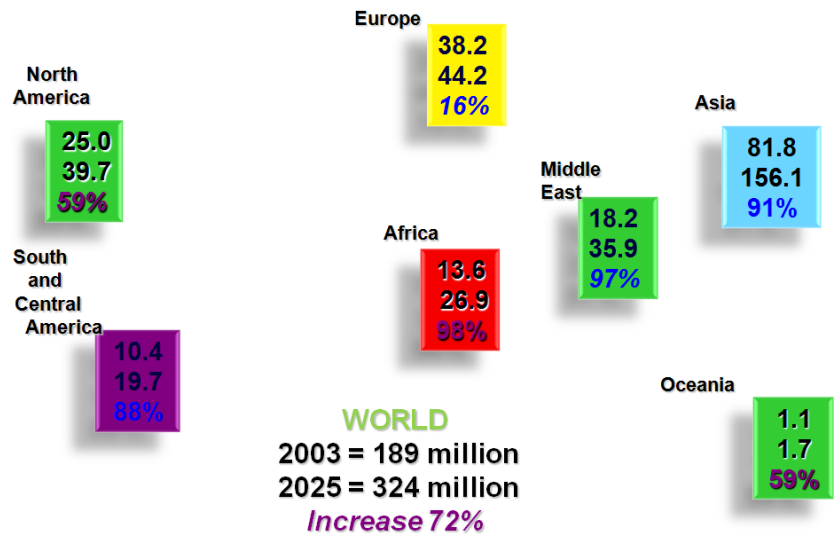
Obesity in the World



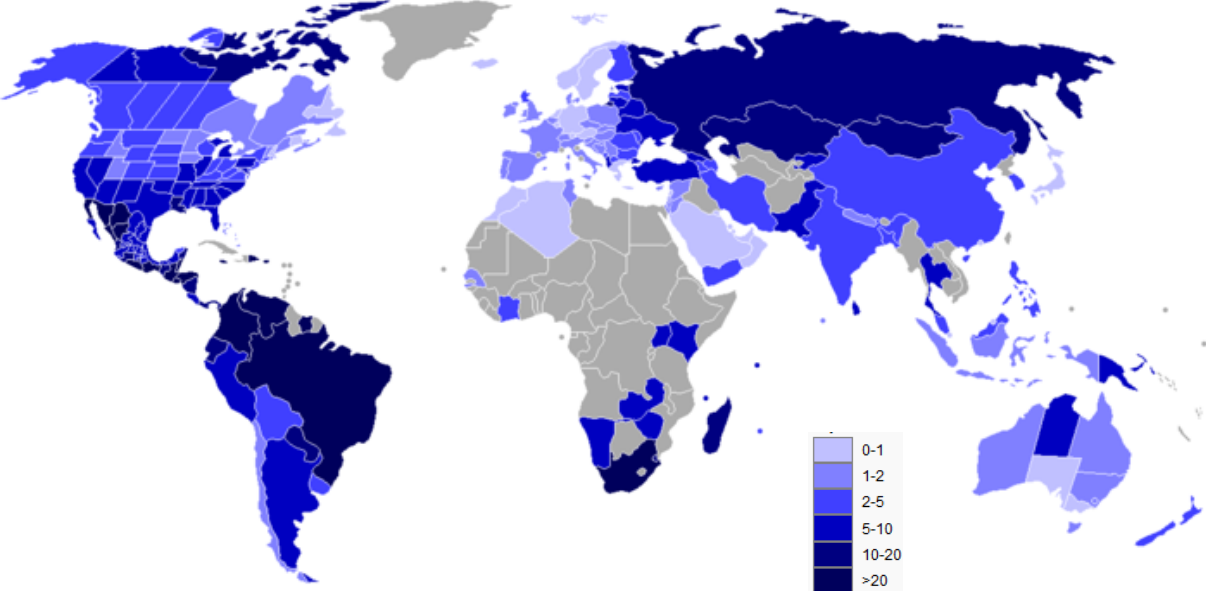
Prevalence of diabetes



Global Projections for the Diabetes Epidemic: 2003-2025 (millions)



Homicide mortality Rate



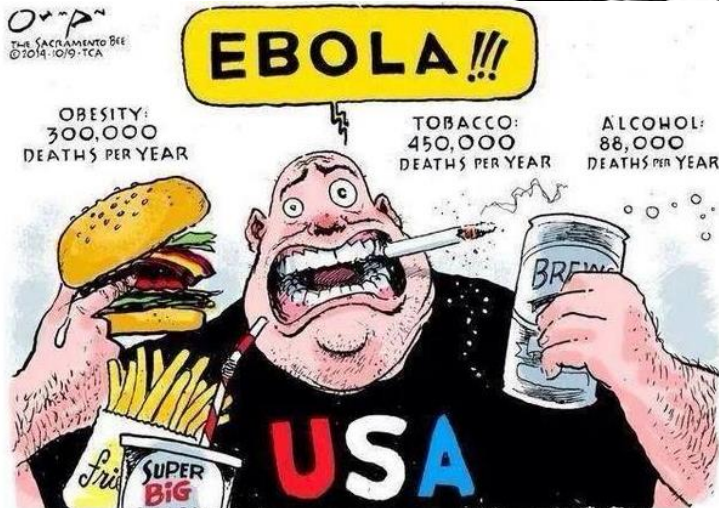
Armed Conflicts



Determinantes das Condições de Saúde e Percepção de Risco por Indivíduos e Sociedade



Figure 2. Formal definitions for risk, uncertainty, ambiguity and ignorance

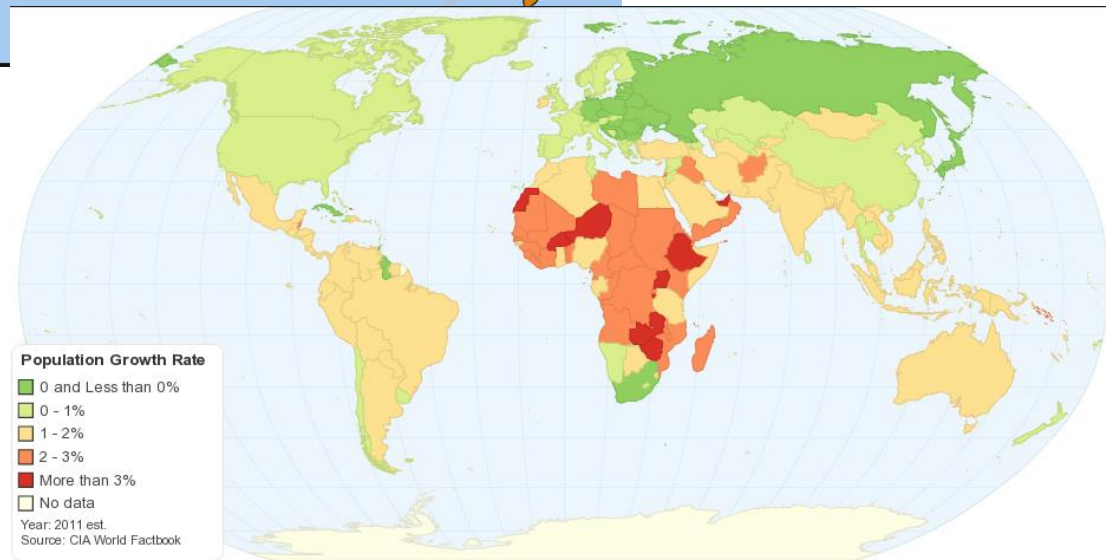
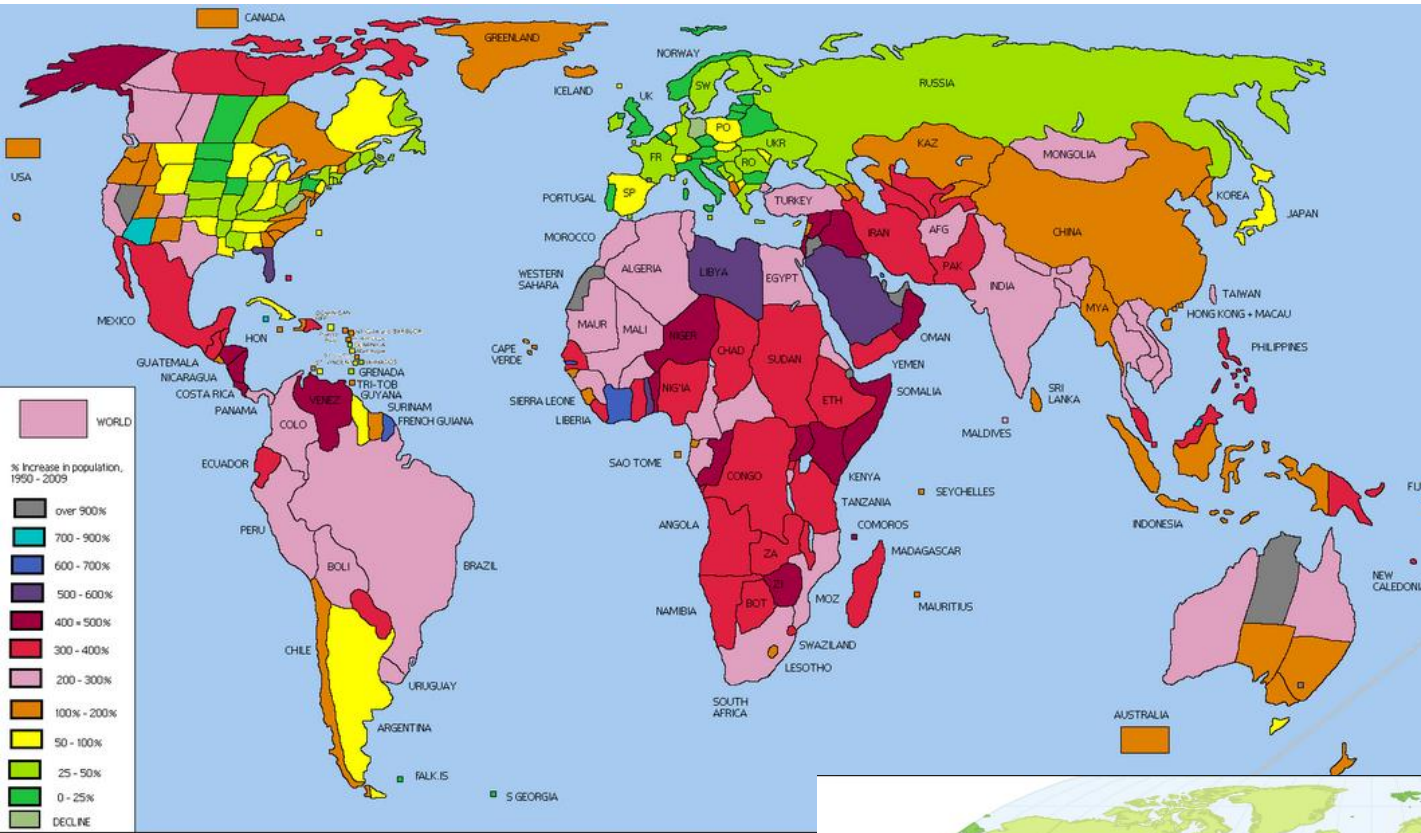


Knowledge about likelihoods	Knowledge about outcomes	
	Outcomes well defined	Outcomes poorly defined
Some basis for probabilities	Risk	Ambiguity
	Incertitude	
No basis for probabilities	Uncertainty	Ignorance

A dinâmica demográfica e os efeitos na saúde

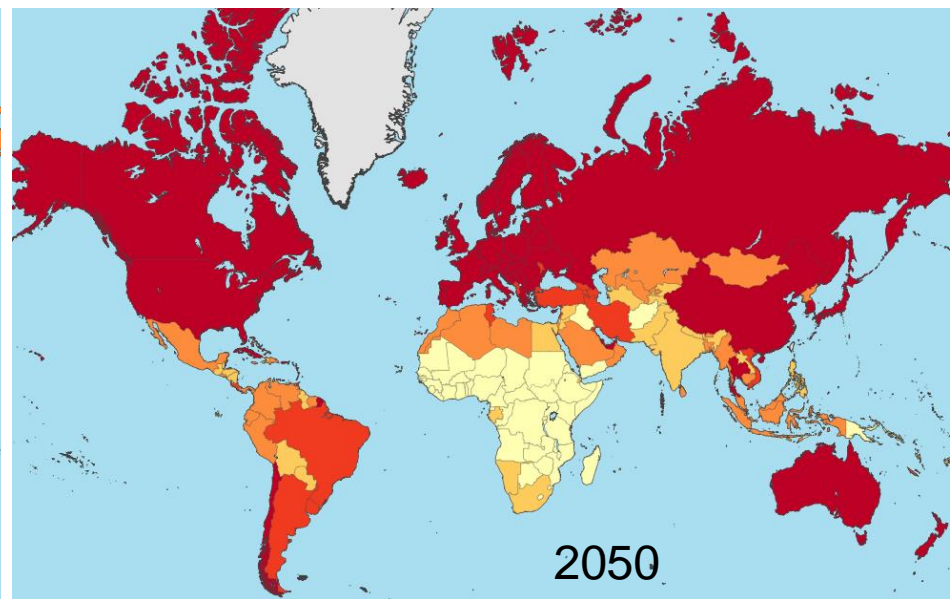
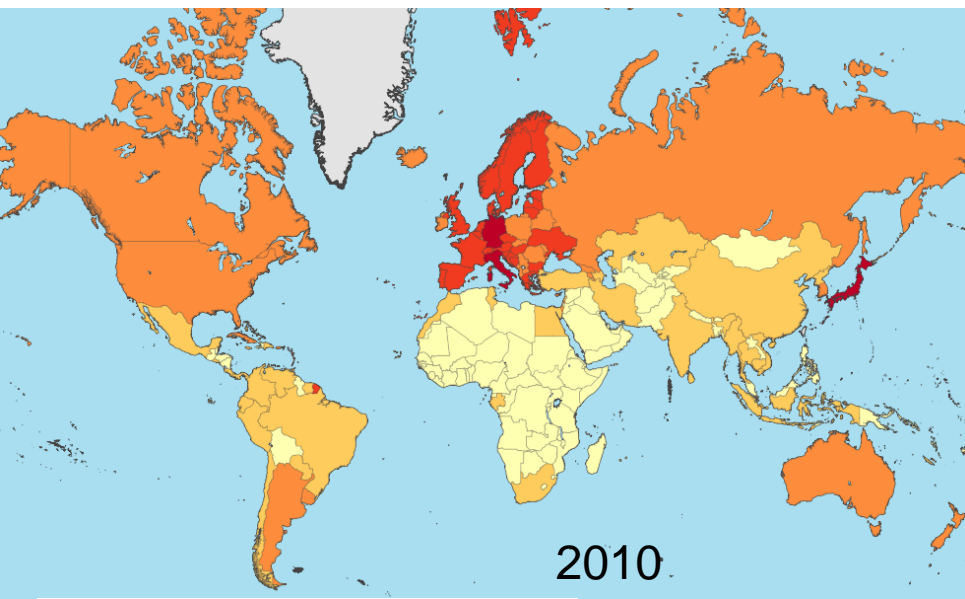
- **Crescimento populacional** – Malthusianismo desacreditado?
- **Envelhecimento**- Até quando podemos viver? E viver saudável?
- **Migrações** – o capital e as mercadorias migram porque não os seres humanos?
- **Urbanização** – as cidades e a complexidade dos sistemas sociais

Between 1950 and 2009 the world population increased by a factor of 2.65, from 2,560 million to 6,800 million.



A dinâmica demográfica e os efeitos na saúde

- Crescimento populacional – Malthusianismo desacreditado?
- **Envelhecimento**- Até quando podemos viver? E viver saudável?
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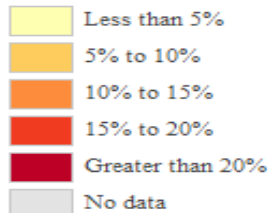
The Aging World

Percent of population 65 or older

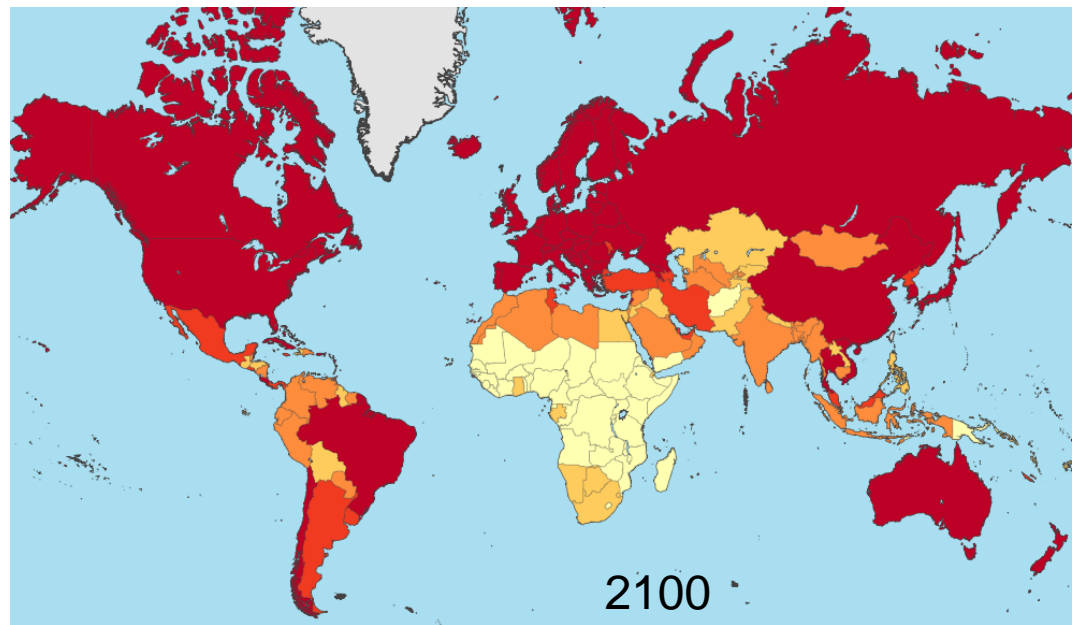
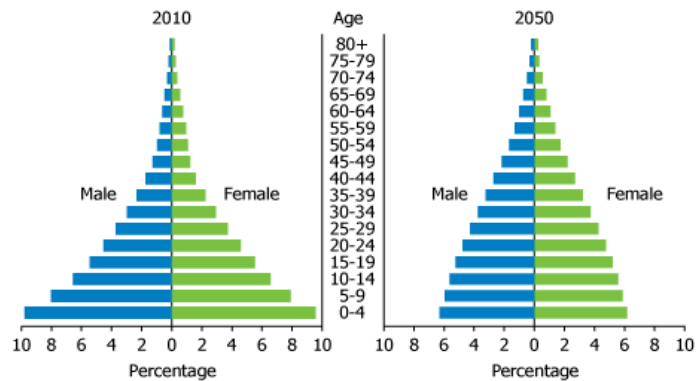
2010

2050

2100



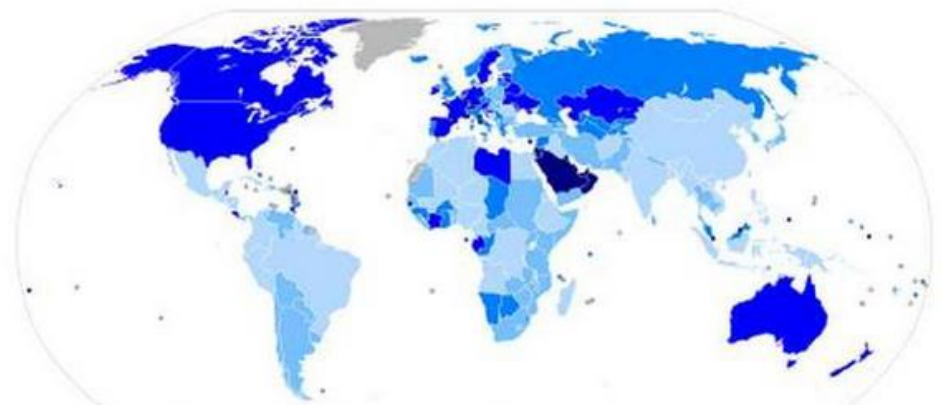
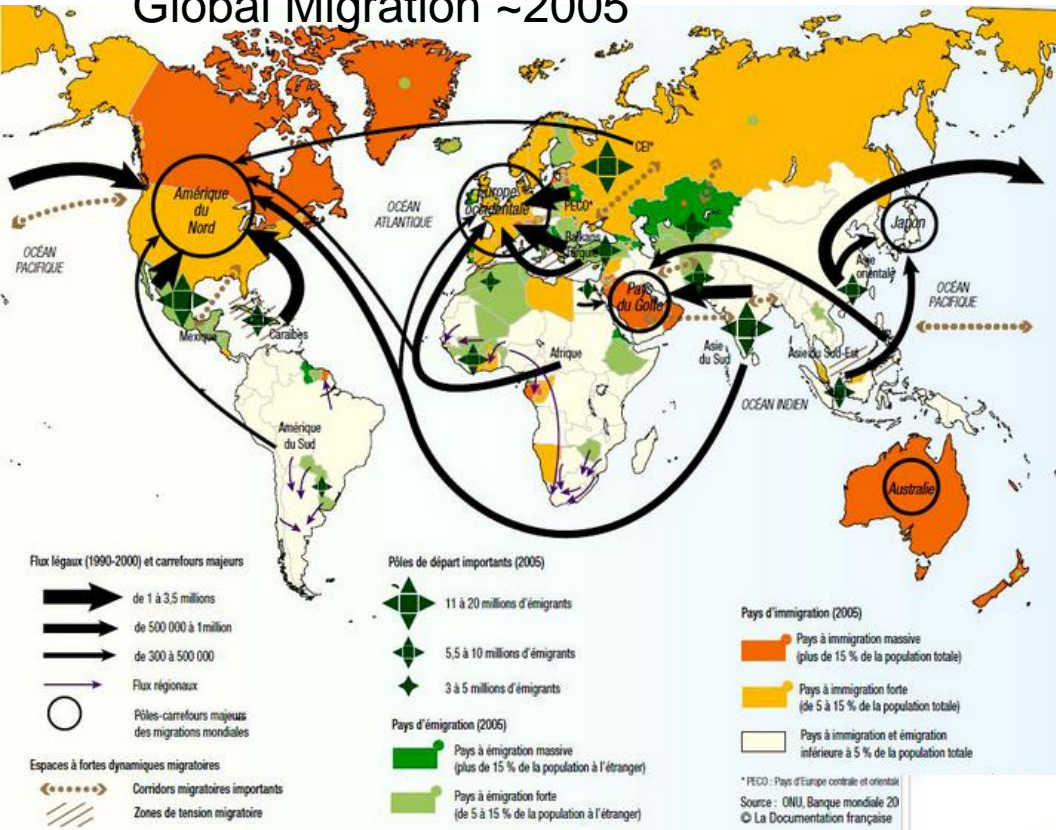
Source: UN Department of Economic and Social Affairs



A dinâmica demográfica e os efeitos na saúde

- Crescimento populacional – Malthusianismo desacreditado?
- Envelhecimento- Até quando podemos viver? E viver saudável?
- **Migrações** – o capital e as mercadorias migram porque não os seres humanos?
- Urbanização – as cidades e a complexidade dos sistemas sociais

Global Migration ~2005



Immigration Map

Map of the world with countries coloured according to their immigrant population as a percentage of total population:

more than 50%	20% to 50%	10% to 20%	4% to 10%	1% to 4%	less than 1%	no data
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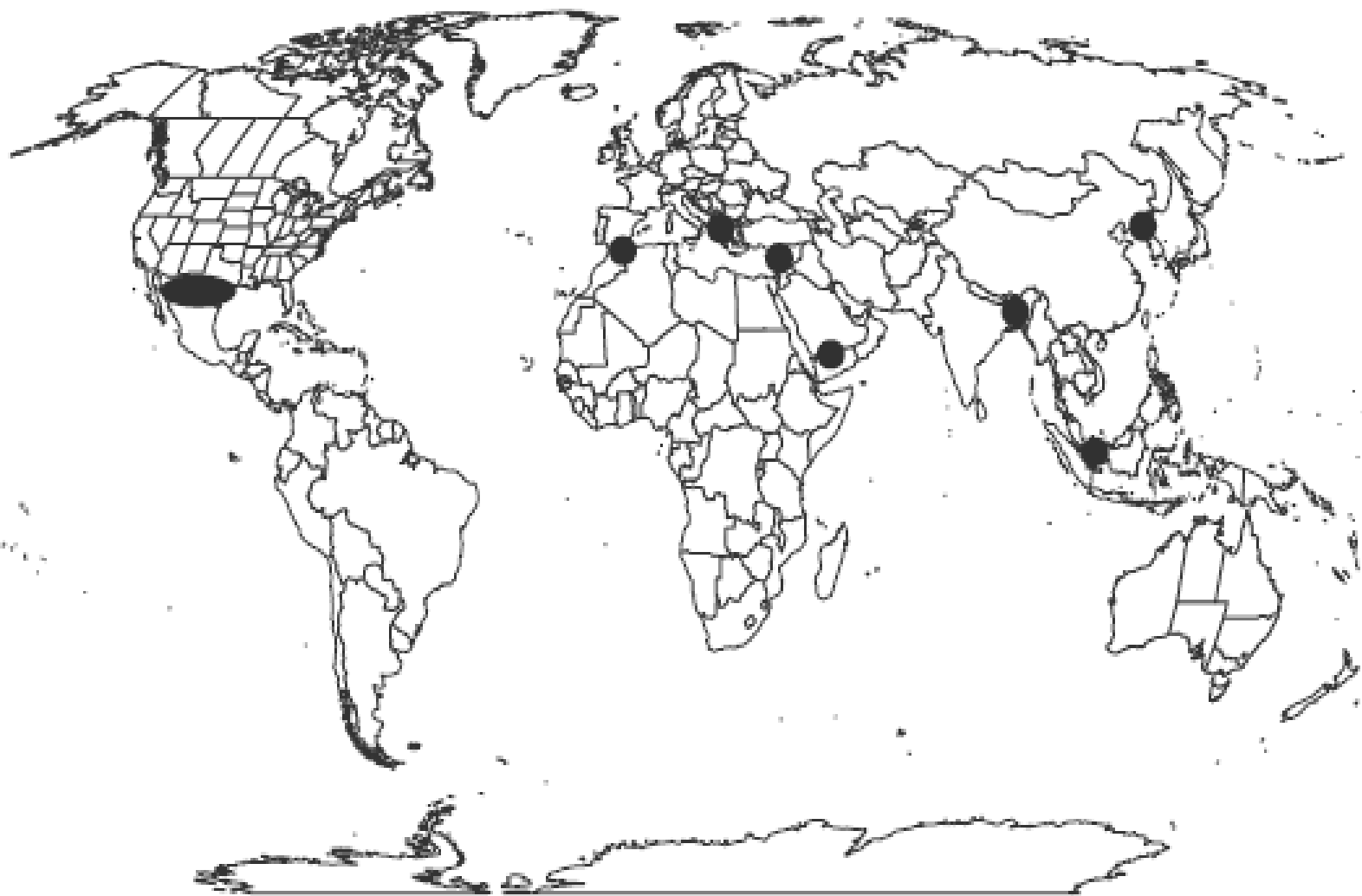


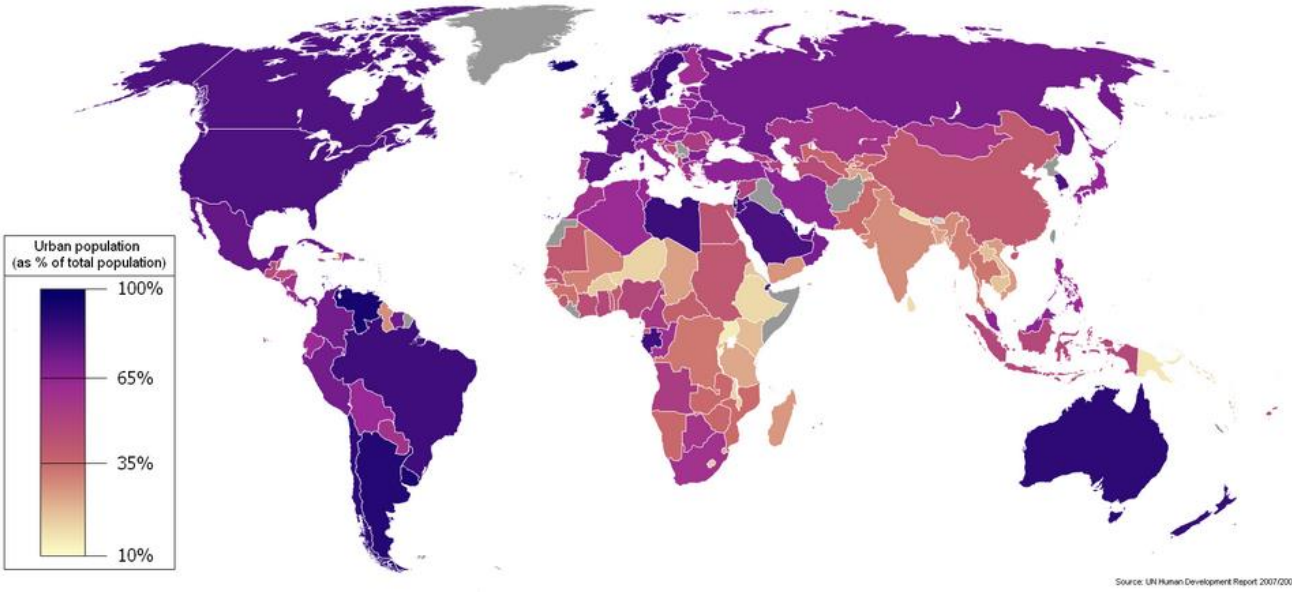
FIGURE 3.5. Walls, fences, and minefields between countries

This map shows the places in the world where borders between one or several neighboring states are closely controlled or made difficult to cross by the erection of barriers (walls, minefields, or fences). These obstacles exist at the places where there are very large differences in mean incomes between neighboring states. See text for discussion of locations.

A dinâmica demográfica e os efeitos na saúde

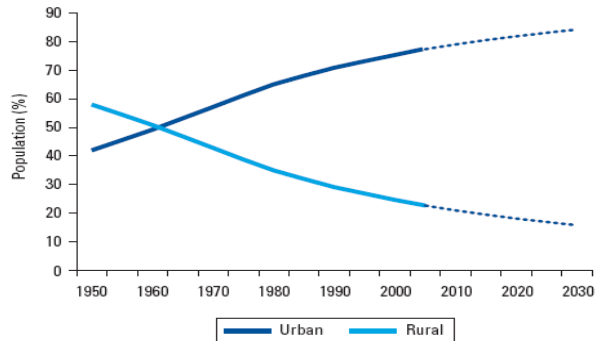
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Urbanization

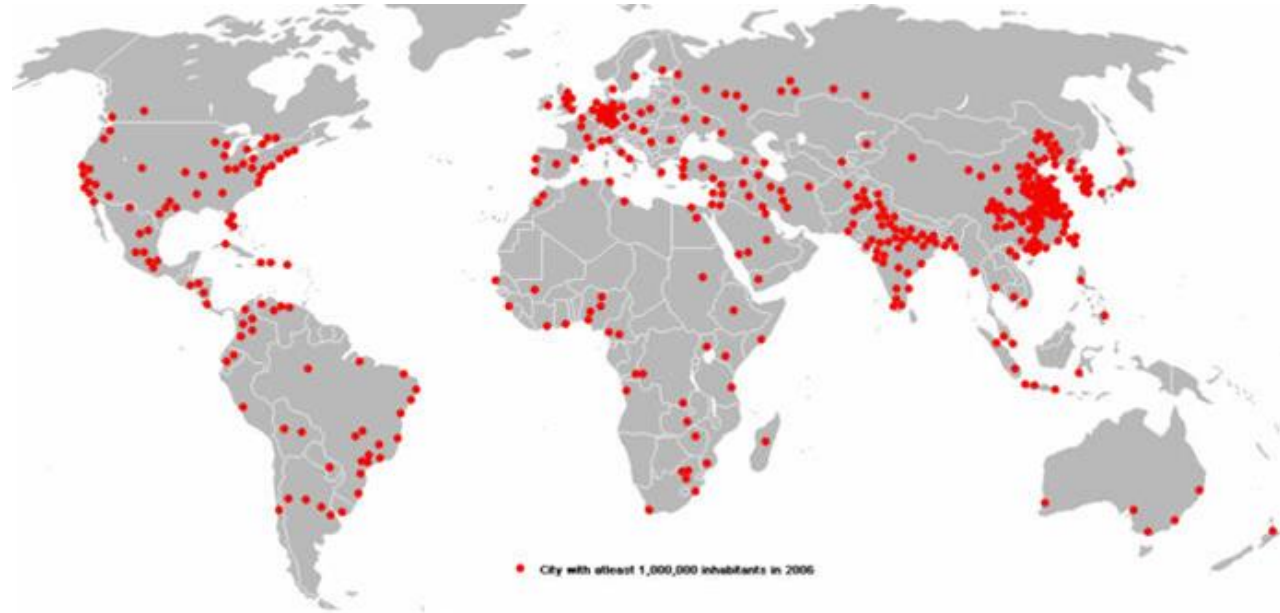


Source: UN Human Development Report 2007/2008

FIGURE 2. Urban and rural population trends and projections in Latin America and the Caribbean, 1950–2030.



Source: United Nations Population Division. World Population Prospects: The 2006 Revision. New York, 2007.

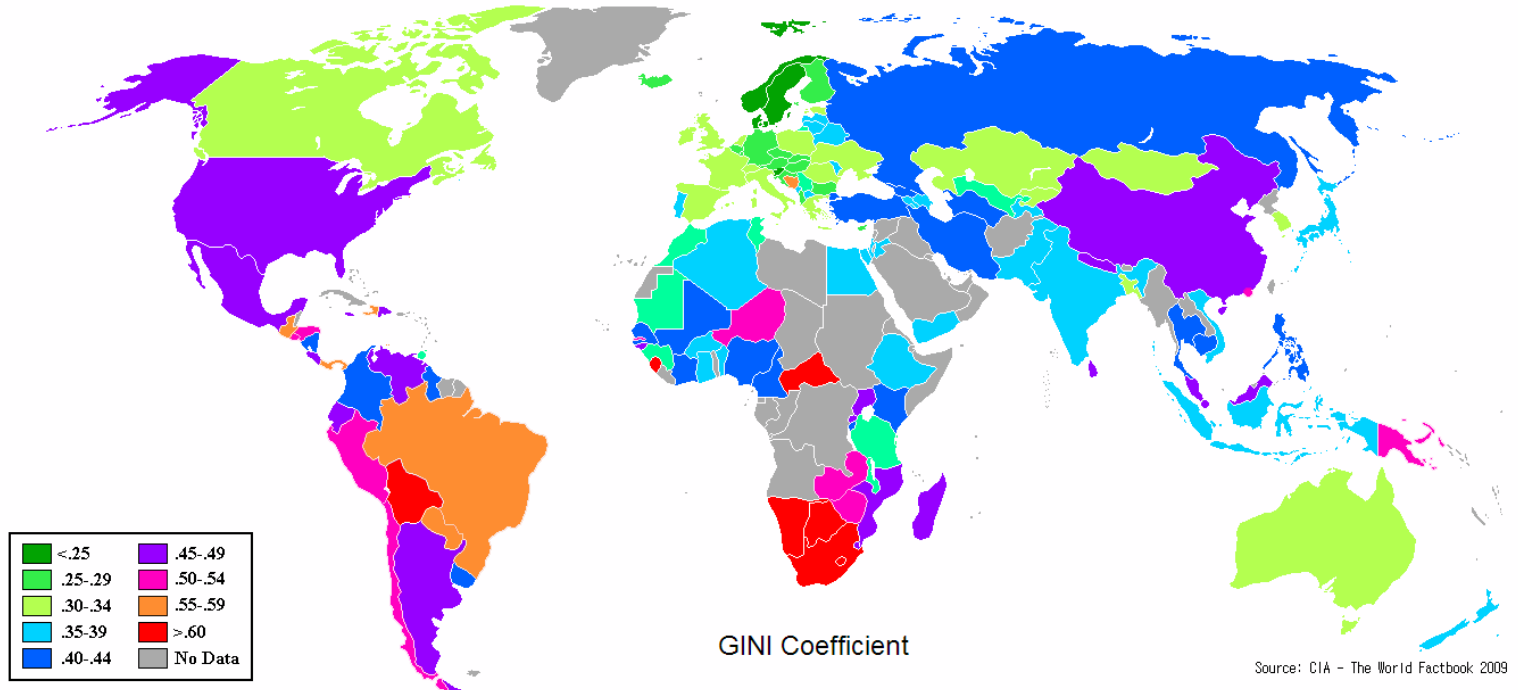


Os determinantes sociais da saúde

- As desigualdades sociais (do local ao internacional)
- O acesso as necessidades básicas (saneamento, habitação, educação etc)
- As políticas sociais

Mapa da Desigualdade

Coeficiente de GINI



The Gini index is a measure of statistical dispersion and is used as a measure of inequality of wealth (eg. income) distribution. It varies from 0 to 1, where a value of 0 corresponds to perfect equality and a value of 1 corresponds to perfect inequality



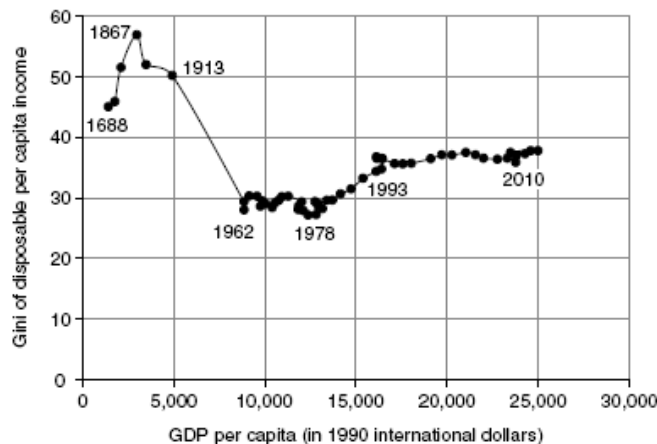
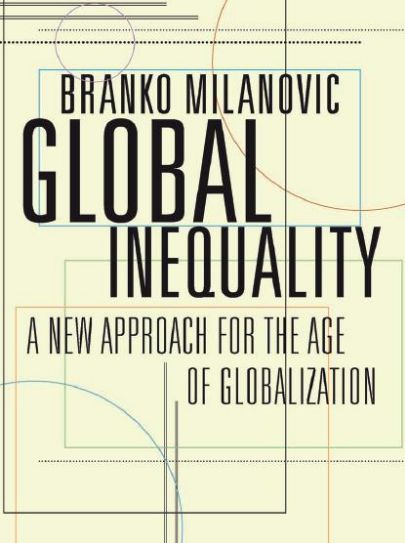


FIGURE 2.11. The relationship between income inequality and mean income (the Kuznets relationship) for the United Kingdom/England, 1688–2010

Data sources: Ginis: for 1688, 1759, 1801, and 1867 from social tables for England/UK reported in Milanovic, Lindert, and Williamson (2011); 1880 and 1913 from Lindert and Williamson (1983, table 2); 1961 to 2010, official UK data (disposable per capita income) kindly calculated and provided by Jonathan Cribb, Institute for Fiscal Studies. GDP per capita from Maddison Project (2013).

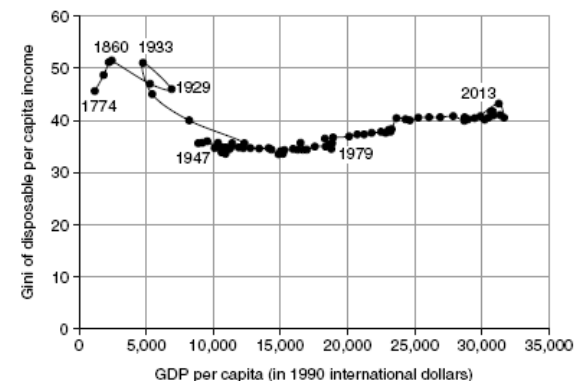


FIGURE 2.10. The relationship between income inequality and mean income (the Kuznets relationship) for the United States, 1774–2013

Data sources: Ginis: 1774, 1850, 1860, and 1870 from social tables created by Lindert and Williamson (2012); 1929 from Radner and Hinrichs (1974); 1931 and 1933 from Smolensky and Plotnick (1992); 1935 to 1950 from Goldsmith et al. (1954); after 1950, from US Census Bureau, *Income, poverty and health insurance coverage in the United States* (various issues); gross income data adjusted to reflect disposable income. GDP per capita from Maddison Project (2013).

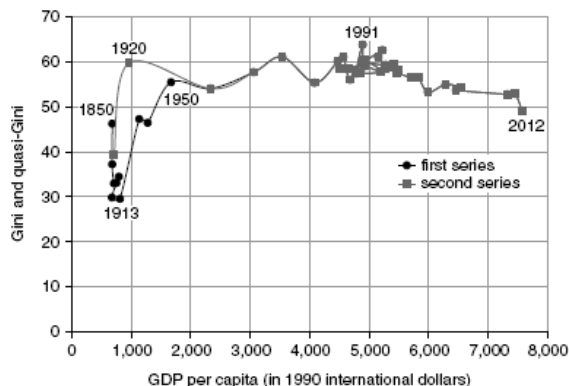


FIGURE 2.16. The relationship between income inequality and mean income (the Kuznets relationship) for Brazil, 1850–2012

This graph shows the Kuznets relationship for Brazil from two different data sets. The first series estimates Ginis from the Williamson ratio (mean income divided by the average unskilled wage); such estimates are called quasi-Ginis. Data sources: Ginis: 1850 to 1950 (first series) from Prados de la Escosura (2007); 1870 to 1920 (second series) from Bértola et al. (2009, table 4); 1960 to 2012, from All the Ginis database (<http://www.gc.cuny.edu/branko-milanovic>). GDP per capita from Maddison Project (2013).

TABLE 2.2. The first and the second Kuznets waves in advanced economies

<i>Country</i>	<i>Peak of Kuznets wave 1</i>			<i>Trough of Kuznets wave 1</i>			<i>Growth-inequality trade-off during the downswing</i>		
	<i>Year of maximum inequality</i>	<i>Level of maximum inequality (Gini points)</i>	<i>GDP per capita in year of maximum inequality (\$PPP)</i>	<i>Year of minimum inequality</i>	<i>Level of minimum inequality (Gini points)</i>	<i>GDP per capita in year of minimum inequality (\$PPP)</i>	<i>Approximate # of years of downswing of Kuznets wave 1</i>	<i>Gini decrease (in points)</i>	<i>GDP increase (# of times)</i>
United States	1933	51	4,800	1979	35	19,000	50	16	4
United Kingdom	1867	57	3,000	1978	27	13,000	110	30	>4
Spain	1953	55	2,500	1985	31	10,000	30	24	4
Italy	1861	51	1,500	1983	30	13,000	120	21	<9
Japan	1937	55	2,300	1981	31	14,000	45	24	6
Netherlands	1732	61	2,000	1982	28	14,000	250	33	7

Note: GDP per capita in 1990 international dollars, from Maddison Project (2013).

Sources: See sources listed for Figures 2.10–2.13, 2.15, and 2.18.

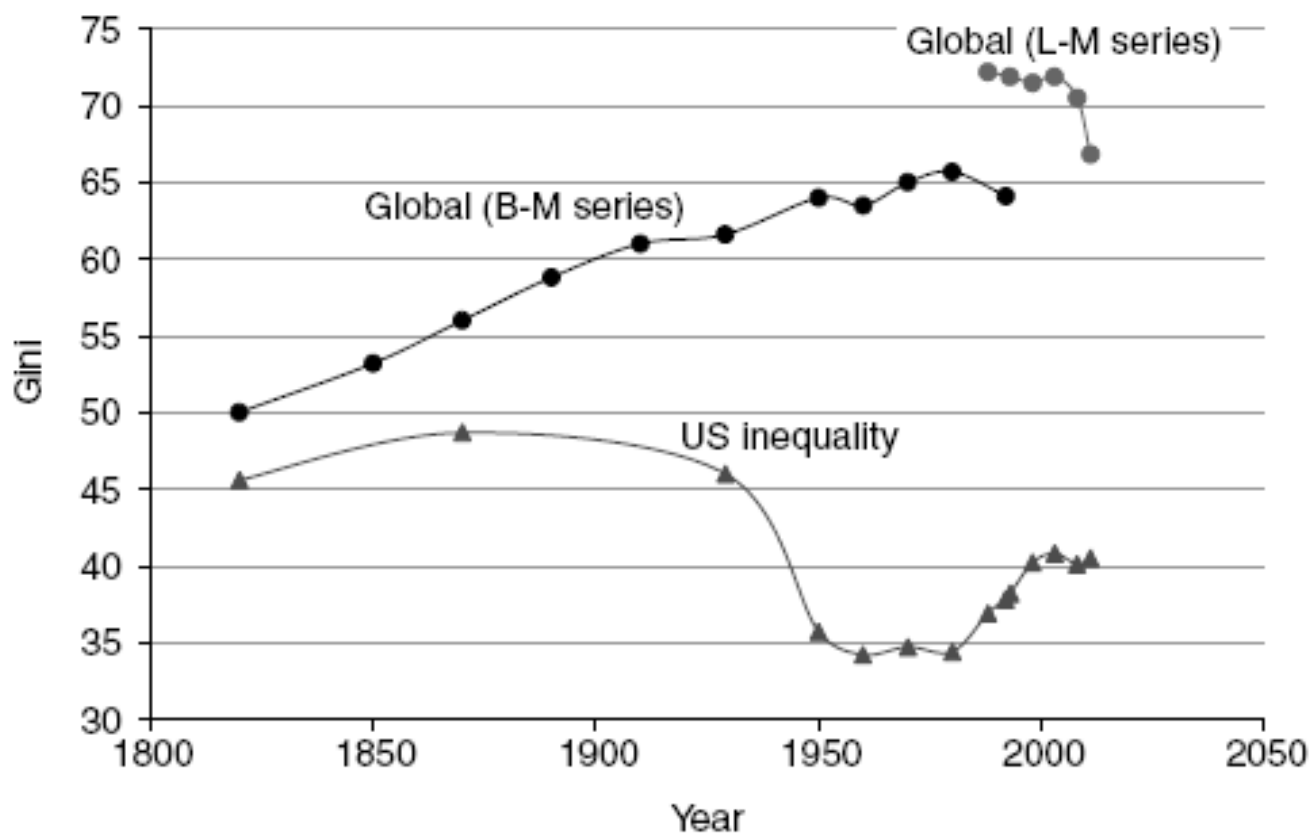
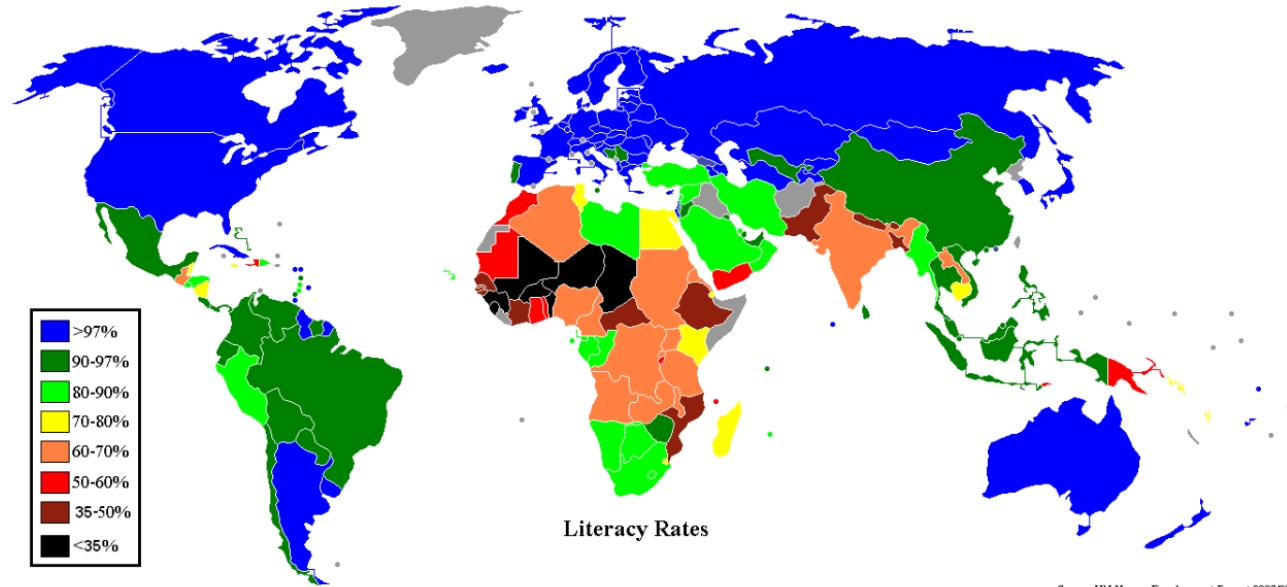


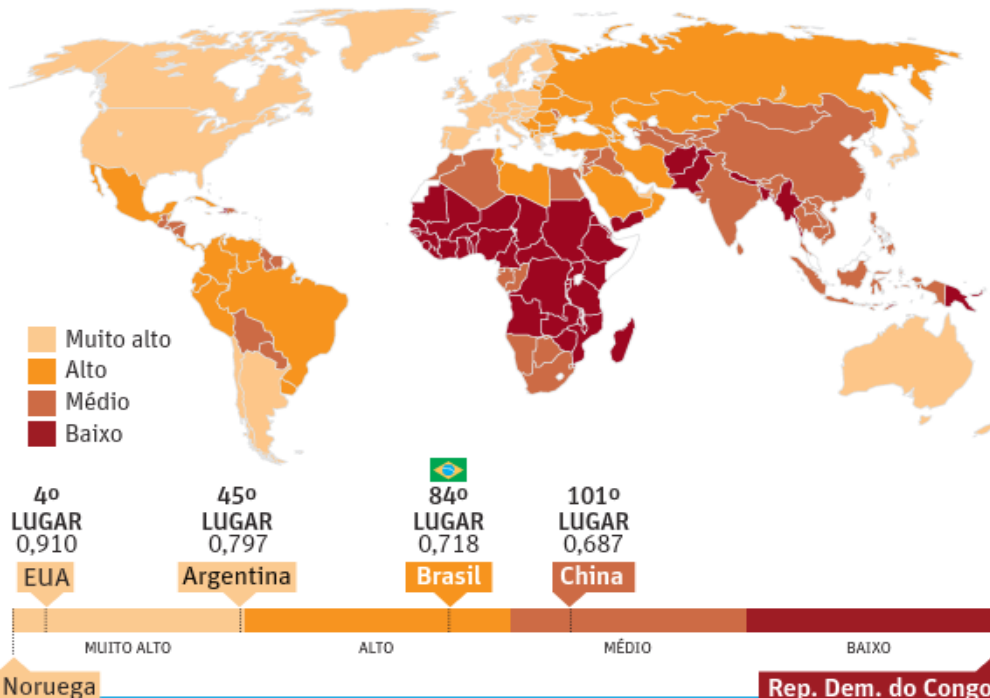
FIGURE 3.2. Global and US inequality, 1820–2011

This graph shows global and US income inequalities (calculated across world and US citizens, respectively). We see that in the recent period, global inequality is decreasing while US inequality is going up. US inequality is, however, much lower than global inequality. Data sources: For US data, see sources listed for Figure 2.10; for global data, see sources listed for Figure 3.1.

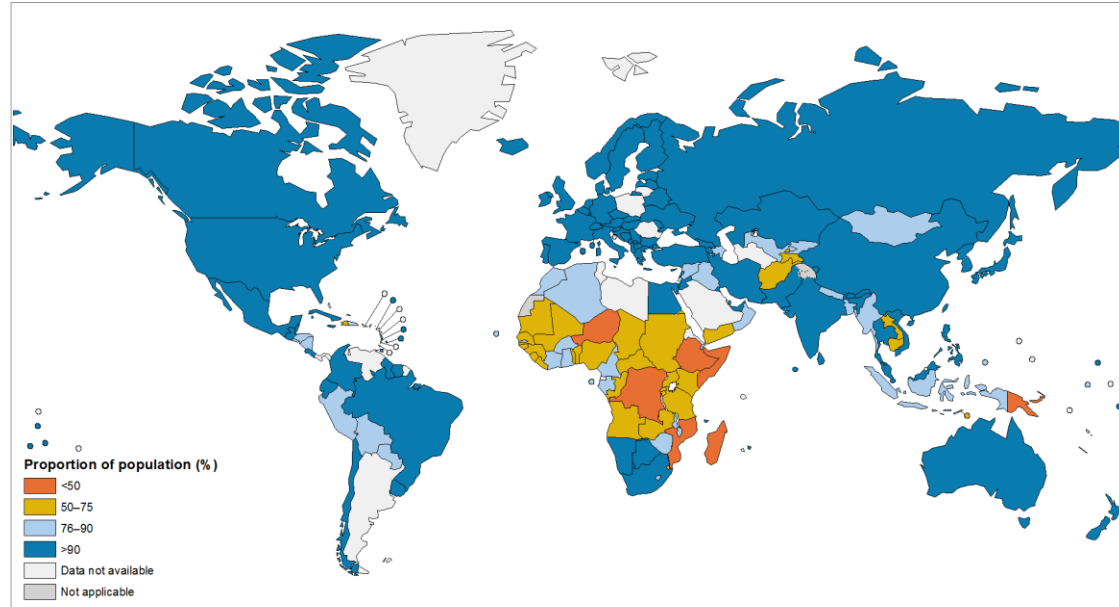
Taxas de Analfabetismo



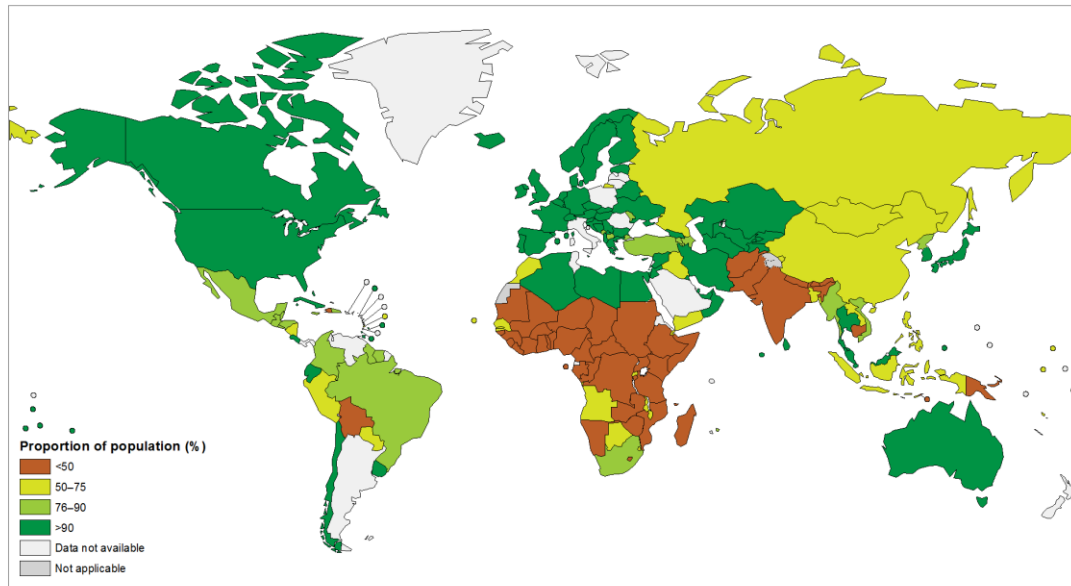
Índice de Desenvolvimento Humano 2011



Proportion of population using improved drinking water sources (%), 2010



Proportion of population using improved sanitation facilities (%), 2010



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Data Source: World Health Organization
Map Production: Public Health Information and Geographic Information Systems (GIS)
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As Políticas Sociais e a Saúde

Programas de transferência condicional de renda

- PTCR fornecem uma renda para famílias pobres com a condição que cumpram algumas condicionalidades, geralmente relacionadas com a saúde e a educação dos filhos.



14

Effect of a conditional cash transfer programme on childhood mortality: a nationwide analysis of Brazilian municipalities



Daíde Razeff, Rosane Aquino, Carlos A T Santos, Rômulo Paes-Sousa, Maurício B. Barreto

Summary

Background In the past 15 years, Brazil has undergone notable social and public health changes, including a large reduction in child mortality. The Bolsa Família Programme (BFP) is a widespread conditional cash transfer programme, launched in 2003, which transfers cash to poor households (maximum income US\$70 per person a month) when they comply with conditions related to health and education. Transfers range from \$18 to \$175 per month, depending on the income and composition of the family. We aimed to assess the effect of the BFP on deaths of children younger than 5 years (under-5), overall and resulting from specific causes associated with poverty: malnutrition, diarrhoea, and lower respiratory infections.

Methods The study had a mixed ecological design. It covered the period from 2004–09 and included 2853 (of 5565) municipalities with death and livebirth statistics of adequate quality. We used government sources to calculate all-cause under-5 mortality rates and under-5 mortality rates for selected causes. BFP coverage was classified as low (0–17·1%), intermediate (17·2–32·0%), high (>32·0%) and target population coverage ≥100% for at least 4 years. We did multivariable regression analyses of panel data with fixed-effects negative binomial models, adjusted for relevant social and economic covariates, and for the effect of the largest primary health-care scheme in the country (Family Health Programme).

Findings Under-5 mortality rate, overall and resulting from poverty-related causes, decreased as BFP coverage increased. The rate ratios (RR) for the effect of the BFP on overall under-5 mortality rate were 0·94 (95% CI 0·92–0·96) for intermediate coverage, 0·88 (0·85–0·91) for high coverage, and 0·83 (0·79–0·88) for consolidated coverage. The effect of consolidated BFP coverage was highest on under-5 mortality resulting from malnutrition (RR 0·35; 95% CI 0·24–0·50) and diarrhoea (0·47; 0·37–0·61).

Interpretation A conditional cash transfer programme can greatly contribute to a decrease in childhood mortality overall, and in particular for deaths attributable to poverty-related causes such as malnutrition and diarrhoea, in a large middle-income country such as Brazil.

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Closing the gap in a generation
Health equity through action on the social determinants of health

This Report is a new international mandate to reinforce research and actions on social determinants of health by public health researchers and professionals





Social protection and tuberculosis control in 21 European countries, 1995–2012: a cross-national statistical modelling analysis

Aaron Reeves, Sanjay Basu, Martin McKee, David Stuckler, Andreas Sandgren, Jan Semenza

Summary

Background WHO stresses the need to act on the social determinants of tuberculosis. We tested whether alternative social protection programmes have affected tuberculosis case notifications, prevalence, and mortality, and case detection and treatment success rates in 21 European countries from 1995 to 2012.

Methods We obtained tuberculosis case notification data from the European Centre for Disease Prevention and Control's 2014 European Surveillance System database. We also obtained data for case detection, treatment success, prevalence, and mortality rates from WHO's 2014 tuberculosis database. We extracted data for 21 countries between Jan 1, 1995, and Dec 31, 2012. Social protection data were from EuroStat, 2014 edition. We used multivariate cross-national statistical models to quantify the association of differing types of social protection programmes with tuberculosis outcomes. All analyses were prespecified.

Findings After we controlled for economic output, public health spending, and country fixed effects, each US\$100 increase in social protection spending was associated with a decrease per 100 000 population in the number of tuberculosis case notifications of -1.53% (95% CI -0.28 to -2.79 ; $p=0.0191$), estimated incidence rates of -1.70% (-0.30 to -3.11 ; $p=0.0201$), non-HIV-related tuberculosis mortality rate of -2.74% (-0.66 to -4.82 ; $p=0.0125$), and all-cause tuberculosis mortality rate of -3.08% (-0.73 to -5.43 ; $p=0.0127$). We noted no relation between increased social spending and tuberculosis prevalence (-1.50% [-3.10 to 0.10] per increase of \$100; $p=0.0639$) or smear-positive treatment success rates (-0.079% [-0.18 to 0.34] per increase of \$100; $p=0.5235$) or case detection (-0.59% [-1.31 to 0.14] per increase of \$100; $p=0.1066$). Old age pension expenditure seemed to have the strongest association with reductions in tuberculosis case notification rates for those aged 65 years or older (-3.87% [-0.95 to -6.78]; $p=0.0137$).

Interpretation Investment in social protection programmes are likely to provide an effective complement to tuberculosis prevention and treatment programmes, especially for vulnerable groups.

Funding European Centre for Disease Prevention and Control.

Lancet Infect Dis 2014;
14: 1105–12

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October 8, 2014
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See [Comment](#) page 1032

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Welfare states and population health: The role of minimum income benefits for mortality

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ABSTRACT

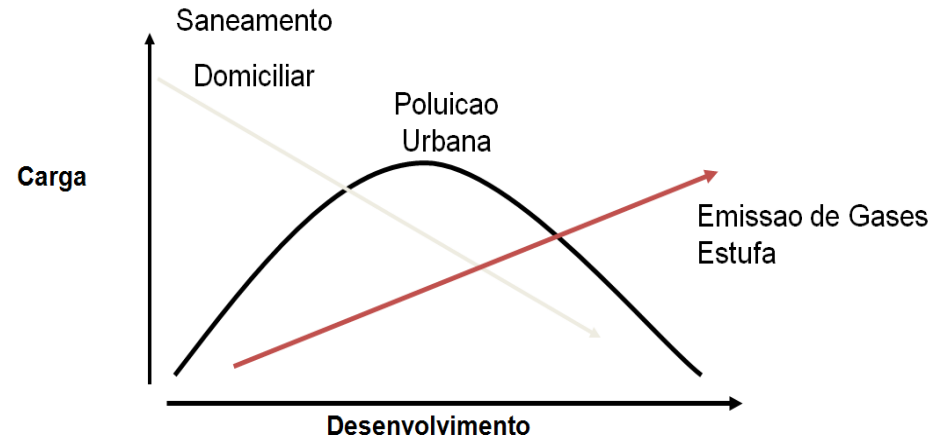
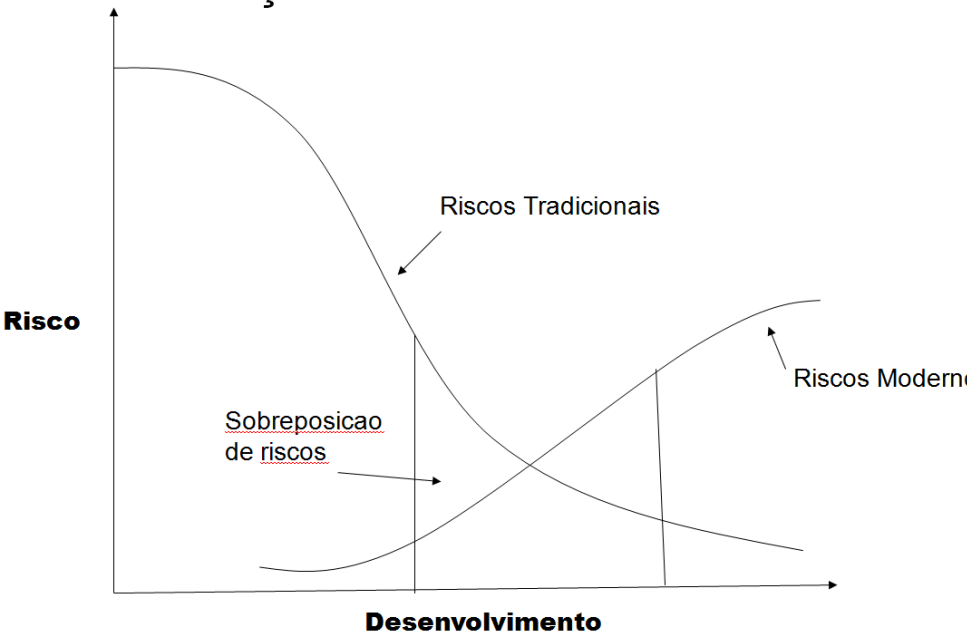
The causes of cross-national differences in population health are subject for intense discussion, often focusing on the role of structural economic factors. Although population health is widely believed to reflect the living conditions in society, surprisingly few comparative studies systematically assess policy impacts of anti-poverty programs. In this paper we estimate the influence of minimum income benefits on mortality using international data on benefit levels in 18 countries 1990–2009. Included are all major non-contributory benefits that low-income households may receive. Our analyses, based on fixed effects pooled time-series regression, show that minimum income benefits improve mortality, measured in terms of age-standardized death rates and life expectancy. The results on country-level links between minimum income benefits and mortality are remarkably robust in terms of measured confounding effects.

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As transformações ambientais e tecnológicas e os persistentes e os novos riscos sobre a saúde

- A transição dos riscos - os riscos se globalizam
- Porque persistem riscos reconhecidos – o caso do fumo
- A revolução tecnológica e a emergência de novos riscos
- A emergência da resistência antimicrobiana
- As mudanças climáticas e as incertezas do futuro

Transição dos Riscos Ambientais



Deslocamento da Carga dos Efeitos Ambientais

Local	→	Global
Imediato	→	Retardado
Riscos a Saúde Humana	→	Riscos a Vida dos Sistemas de Suporte

Why persist recognized risks - the case of smoking

Tobacco Control

• **No. 1 Global Killer:** ~ 5 Million/Year Presently

~ 8-9 Million/Year by 2030

- **Rising Death Toll in LMIC:** 80% of Deaths by 2030
- **TC:** Cost – Effective and High Impact Intervention for NCD Prevention and Control (WHO; WB)
- Even if global reduction in Prevalence of tobacco consumption is decreases by 1% annually – total number of smokers in developing countries will increase, by 2020 and 2050 (ECOSOC 2002)

NUMBER OF CIGARETTE SMOKERS (in millions)

	BEST CASE SCENARIO			NO PROGRESS SCENARIO	
	2000	2020	2050	2020	2050
Developed	196.5	177.0	134.7	216.4	222.6
Developing	977.3	1055.2	1093.4	1290.1	1807.2
Economies in Transition	108.0	90.1	60.4	110.2	99.8
World	1282.5	1385.1	1341.8	1693.5	2217.9

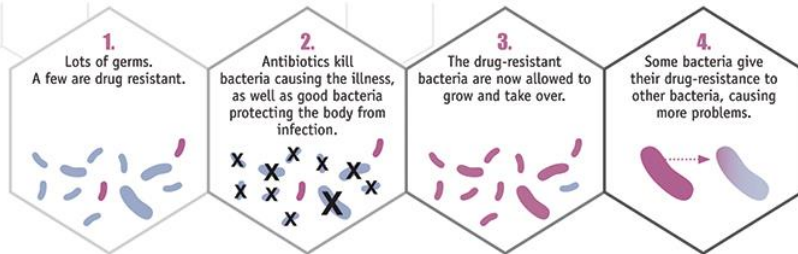
The technology revolution and emergence of new risks

Antimicrobial resistance

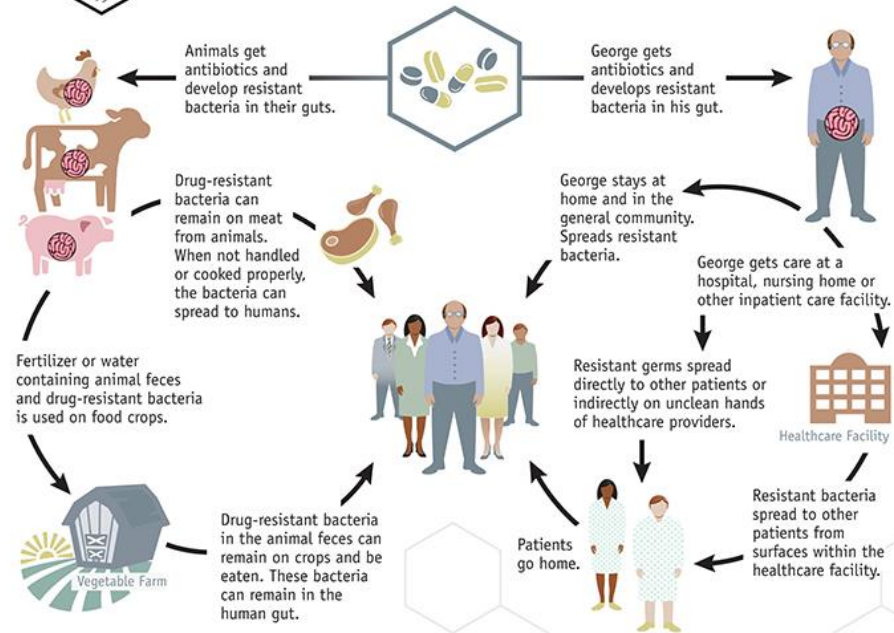
Key facts

- Antimicrobial resistance threatens the effective prevention and treatment of an ever-increasing range of infections caused by bacteria, parasites, viruses and fungi.
- It is an increasingly serious threat to global public health that requires action across all government sectors and society.

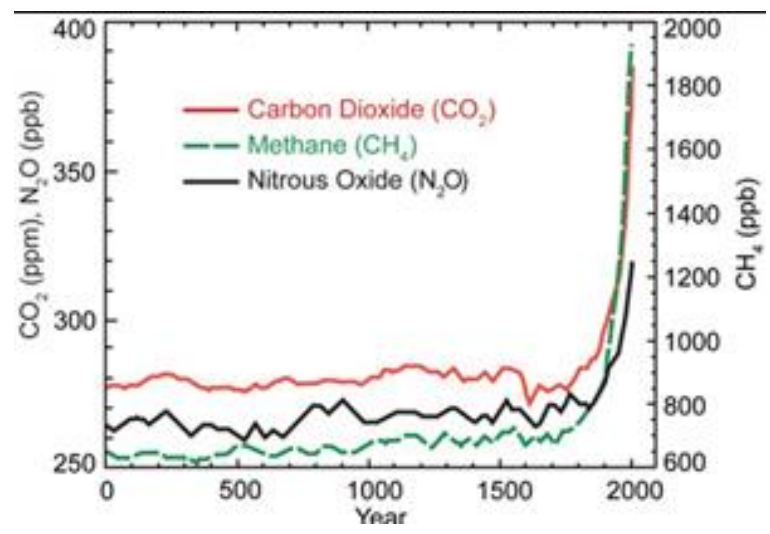
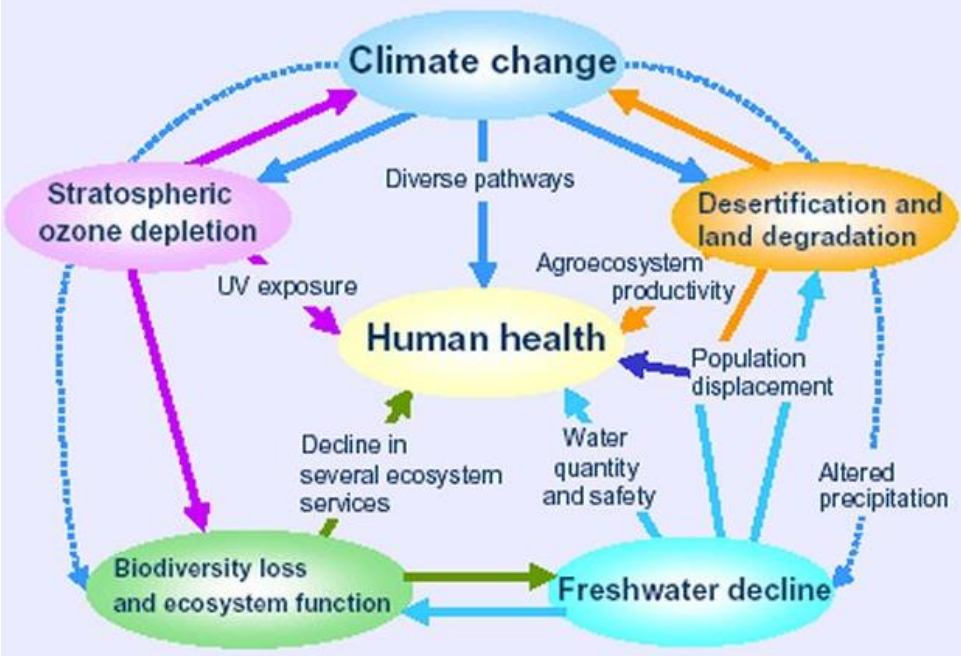
How Antibiotic Resistance Happens



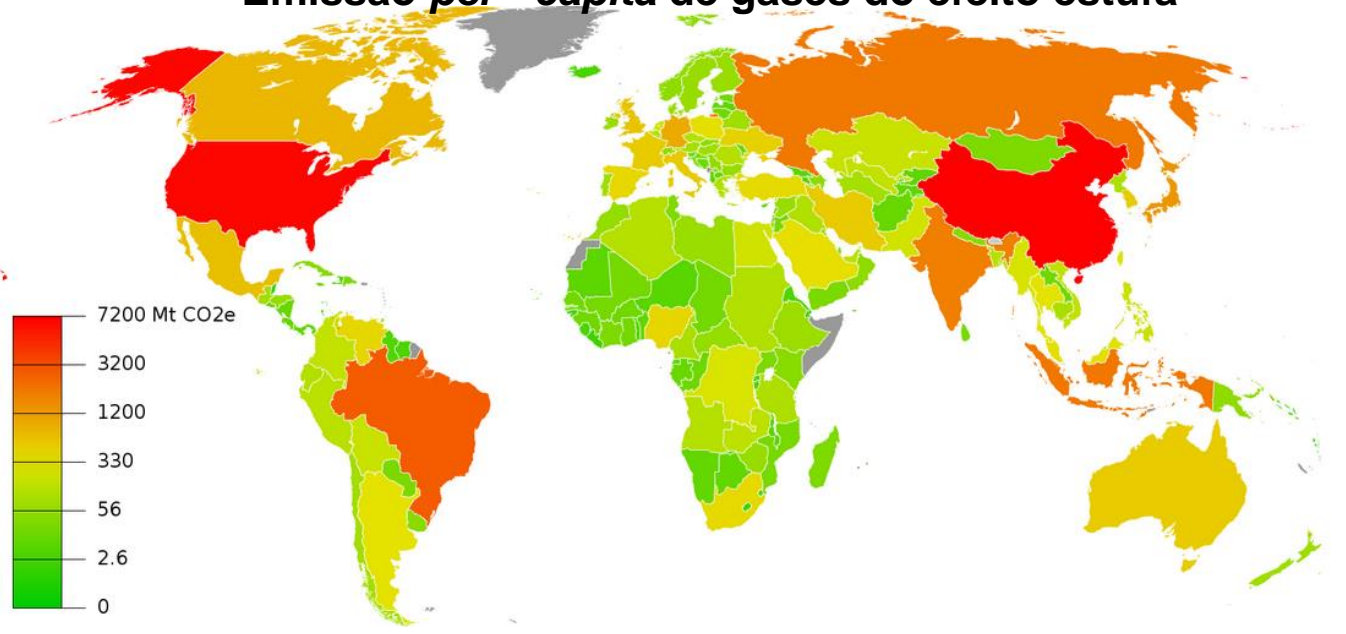
Examples of How Antibiotic Resistance Spreads



Simply using antibiotics creates resistance. These drugs should only be used to treat infections.



Emissão per - capita de gases do efeito estufa



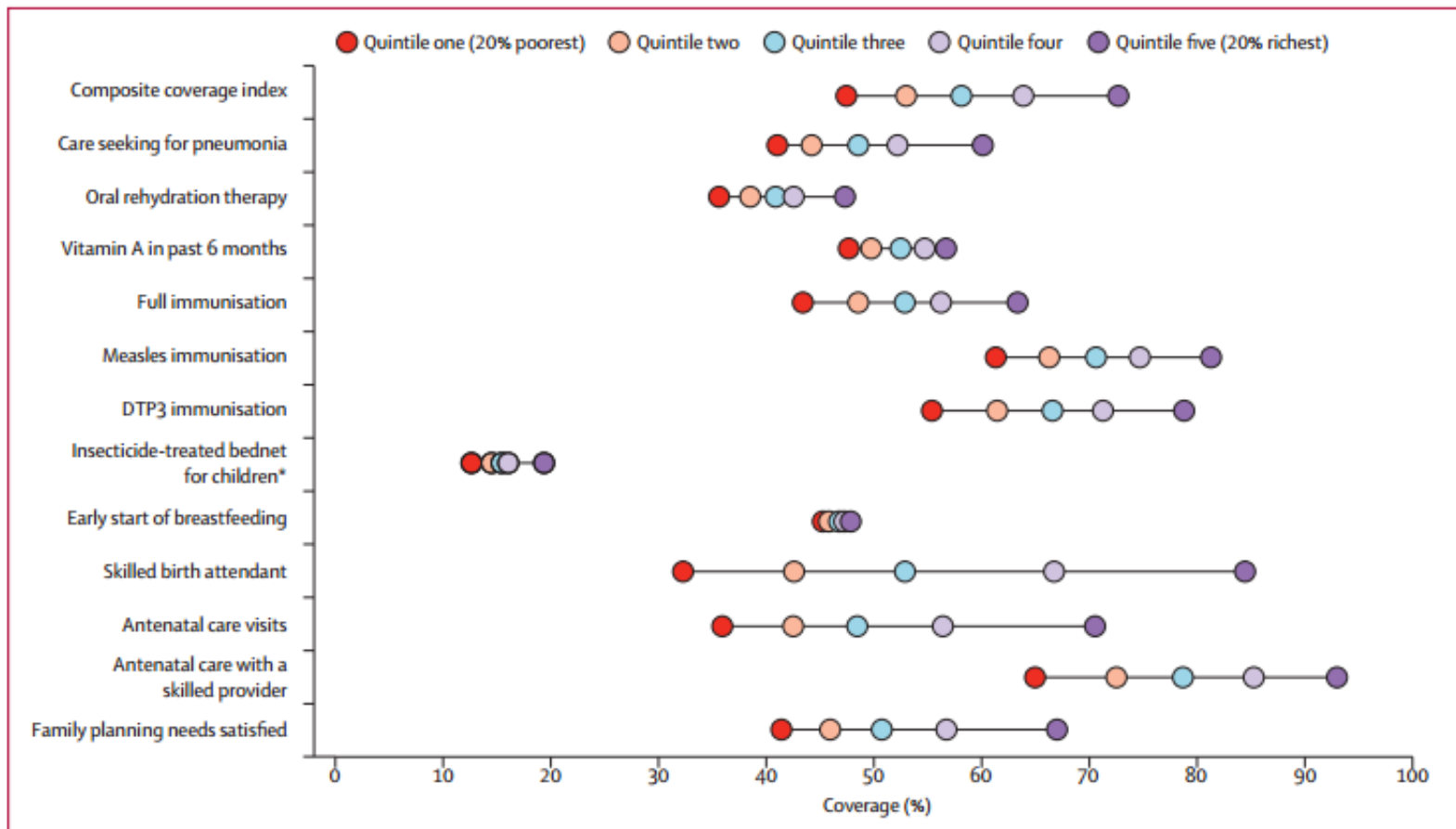
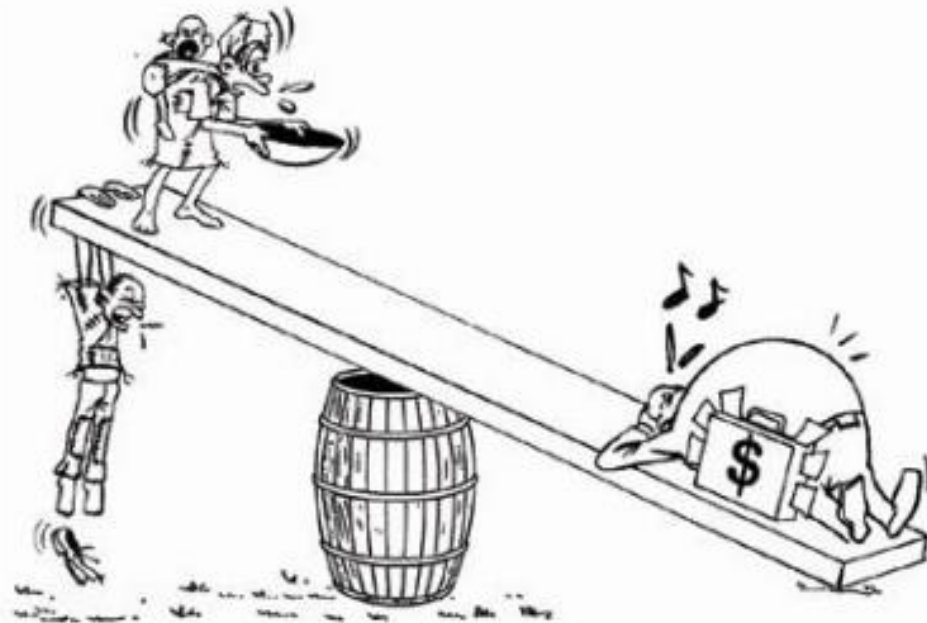


Figure 1: Mean coverage in each wealth quintile for the studied interventions in 54 Countdown countries

Coloured dots show the average coverage in each wealth quintile. Q1 is the 20% poorest wealth quintile; Q5 is the 20% richest. The distance between quintiles 1 and 5 represents absolute inequality. *Appendix p 1 specifies age ranges of children.

90-10 Gap: Only 10% of worldwide expenditure on health research and development is devoted to the problems that primarily affect the poorest 90% of the world's population (Global Forum for Health Research)

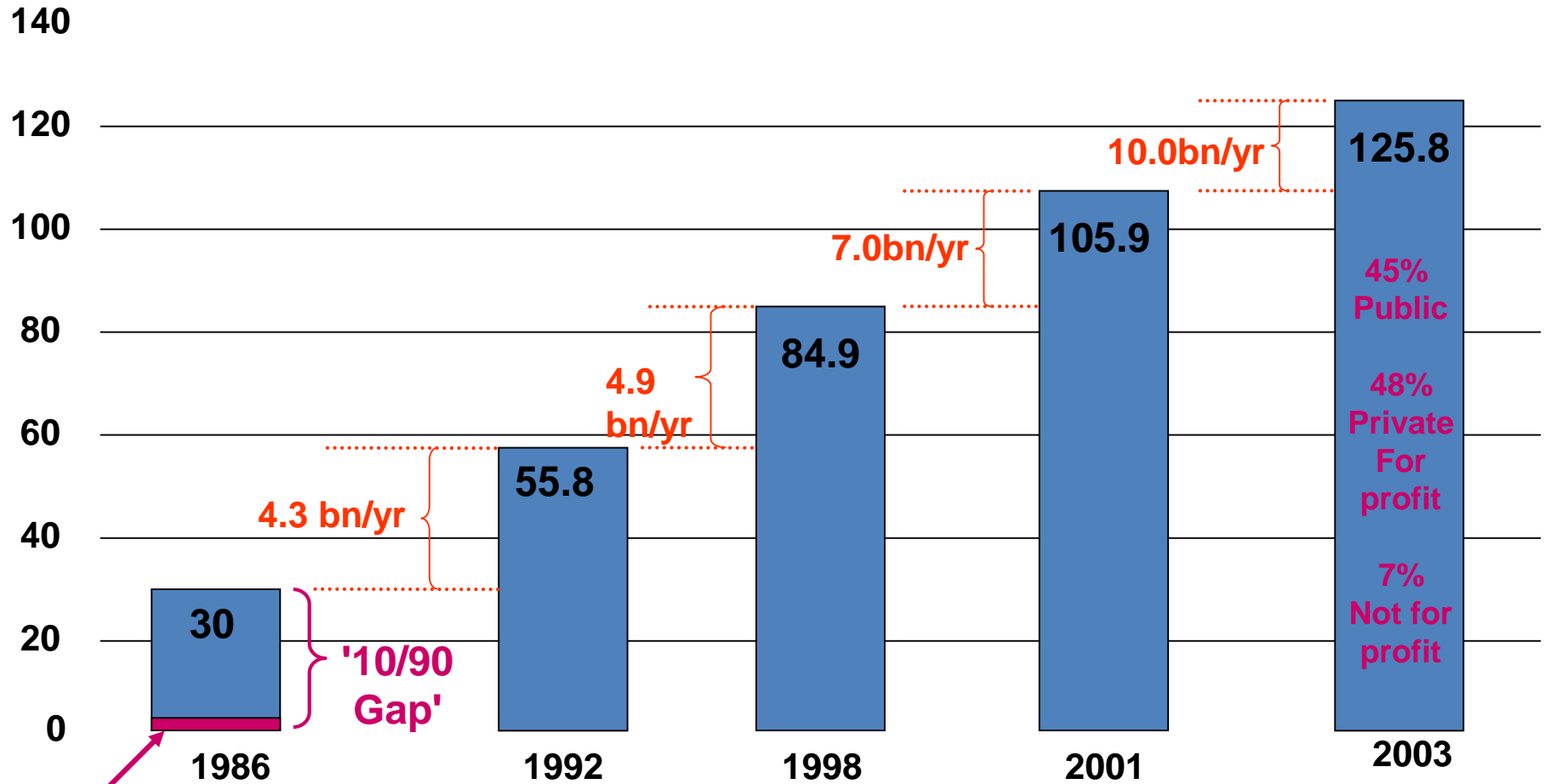


Picture From: *Changing Minds: A Guide to Facilitated Participatory Planning* by Cole P. Dodge and Gavin Bennet



US\$ bn


Global health research expenditure – 10/90 Gap



US\$ 1.6 bn (5%) for LMIC health needs

Respostas

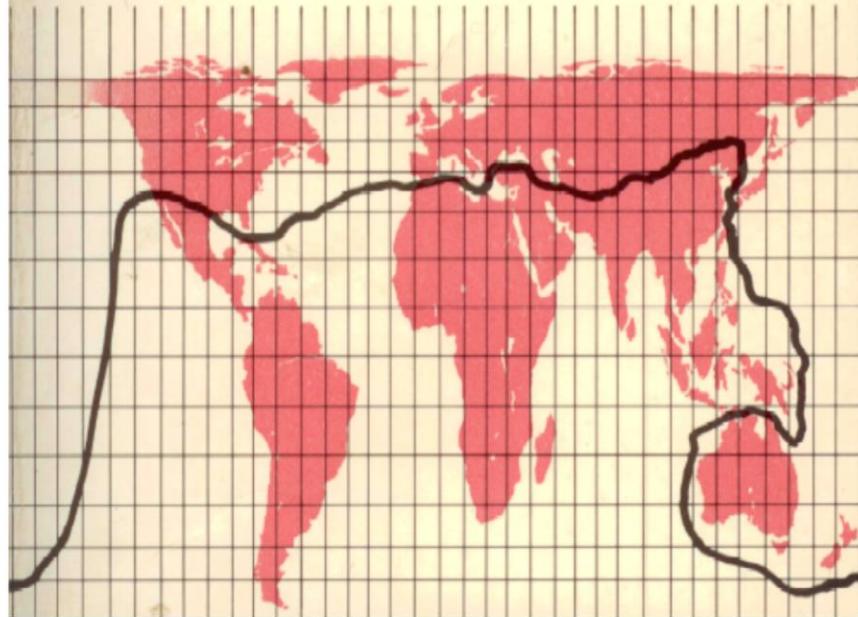
- Respostas das agências internacionais (MDGs, SDGs, International Health Regulations-IHR, The United Nations Framework Convention on Climate Change, WHO Framework Convention on Tobacco Control, Global action plan on antimicrobial resistance, Global Plan of Action on Social Determinants of Health etc)
- Respostas locais/nacionais

Pan  World Affairs

NORTH- SOUTH:

A PROGRAMME FOR SURVIVAL

The Report of the Independent
Commission on International
Development Issues under the
Chairmanship of Willy Brandt



1979

Foreword by Willy Brandt, 1979

“There has been much to talk about a North-South dialogue. And there have been serious contribution to it. But there has also been a tremendous waste of opportunities and goodwill. The difficult and controversial subjects which divide richer and poorer countries will certainly not be solved by prejudices, not by wishful thinking. They must be approached with a will to overcome dangerous tensions and to produce significant and useful results for nations and regions – but, first and foremost, for human beings – in all parts of the world”

Closing the gap in a generation

This Report is a new international mandate to reinforce research and actions on social determinants of health by public health researchers and professionals

Health equity through action on
the social determinants of health



The Commission's overarching recommendations

1 Improve Daily Living Conditions

Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

2 Tackle the Inequitable Distribution of Power, Money, and Resources

In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

3 Measure and Understand the Problem and Assess the Impact of Action

Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

Algumas reflexões finais

- **Desigualdades vs. Iniquidades**
- Tecnologia médicas vs. Políticas Sociais/Ambientais

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The Lancet–University of Oslo Commission on Global Governance for Health

The political origins of health inequity: prospects for change

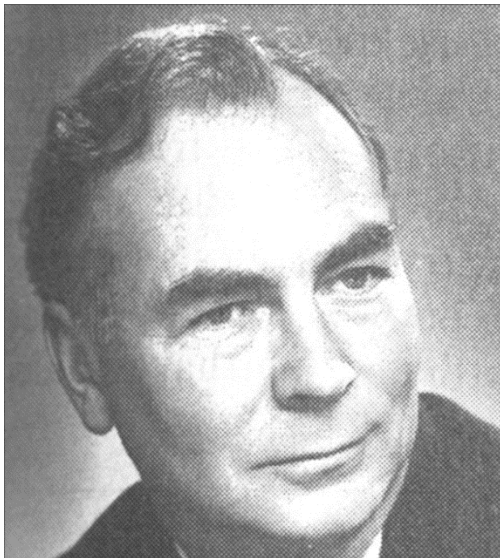
Ole Petter Ottersen, Jashodhara Dasgupta, Chantal Blouin, Paulo Buss, Virasakdi Chongsuvivatwong, Julio Frenk, Sakiko Fukuda-Parr, Bience P Gawanas, Rita Giacaman, John Gyapong, Jennifer Leaning, Michael Marmot, Desmond McNeill, Gertrude I Mongella, Nkosana Moyo, Sigrun Møgedal, Ayanda Ntsaluba, Gorik Ooms, Espen Bjertness, Ann Louise Lie, Suerie Moon, Sidsel Roalkvam, Kristin I Sandberg, Inger B Scheel

Key messages

- The unacceptable health inequities within and between countries cannot be addressed within the health sector, by technical measures, or at the national level alone, but require global political solutions
- Norms, policies, and practices that arise from transnational interaction should be understood as political determinants of health that cause and maintain health inequities
- Power asymmetry and global social norms limit the range of choice and constrain action on health inequity; these limitations are reinforced by systemic global governance dysfunctions and require vigilance across all policy arenas
- There should be independent monitoring of progress made in redressing health inequities, and in countering the global political forces that are detrimental to health
- State and non-state stakeholders across global policy arenas must be better connected for transparent policy dialogue in decision-making processes that affect health
- Global governance for health must be rooted in commitments to global solidarity and shared responsibility; sustainable and healthy development for all requires a global economic and political system that serves a global community of healthy people on a healthy planet

Algumas reflexões finais

- Desigualdades vs. Iniquidades nacionais e globais
- **Tecnologia médicas vs. Políticas Sociais/Ambientais**



Thomas McKeown (1912-1978)

