Health Inequities in Brazil:
Our most serious disease

Document presented at the launch of the Brazilian National
Commission on Social Determinants of Health (NCSDH)

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Introduction

Health inequities between groups or individuals – that is, health inequalities that are not only systemic and relevant, but also avoidable, unfair and unnecessary, in Margareth Whitehead’s words – are one of the aspects that best define health in Brazil. The average national infant mortality rate, according to information from the Ministry of Health for 2004, was 23.1 per thousand live births. However, this figure shows large regional disparities (rates lower than 10 per thousand live births in a few municipalities in the South and Southeastern regions and higher than 50 in areas of the Northeastern region).

According to UNICEF’s report of 2006 on the Brazilian childhood, in 2000, the mortality rate in under-five children of women with three or less years of education was of 49.3 per thousand live births – a number almost 2.5 times larger than under-five children of mothers with eight or more years of education.

The child of a woman with one or less years of education is 23 times more liable to be illiterate at the beginning of adolescence than the child of a woman with 11 years of education or more.

The fact that the major determinants of inequities are related to the way social life is organized has been agreed upon for a long time. In the mid-19th century, Virchow understood that “medical science is inextricably and essentially a social science”, that is, that the economic and social conditions exert an important influence on health and disease and that such interrelations should be subjected to scientific research. He also understood that the term “public health” had a political content and that its praxis should necessarily
include interventions in the political and social life in order to overcome obstacles that hinder the health of the population from being better.

Since then, a lot of progress has been obtained in the development of explanatory models that analyze the relation between the way a given society is organized throughout time and the health conditions of its people. One of the main challenges of these explanatory models is the establishment of a hierarchy for determining interrelations between general aspects such as social, economic and political factors and the way through which these factors affect the health of groups and individuals. This set of interrelations allows us to understand why the correlation between general wealth indexes of a given society, such as the GDP, and health indexes is not constant. The amount of wealth a society generates is certainly an essential factor in providing better life and health conditions to its people. However, there are numerous examples of countries with larger total or *per capita* GDPs that, nevertheless, show much less satisfactory health indexes than countries with lower GDPs.

Moreover, in the last few years, there was an increase in the quantity and an improvement in the quality of studies on the existing associations between the health of populations, the inequalities in life conditions and the level of development of the network of social connections that take place between individuals and groups. These studies allow us to affirm that, once a certain level of economic growth has been obtained, additional increases in wealth are not necessarily translated into significant improvements in health conditions. From this level of wealth on, the most important factor that explains the general health situation of a country is not its total wealth, but the way it is distributed.

In other words, inequalities in income distribution do not harm only the poorer groups, but the society as a whole. Middle-income groups in countries with high levels of income inequality present worse health conditions than groups with lower incomes in equitable societies. A comparative study between states in the USA revealed that individuals living in states with large income disparities display worse health conditions than those living in states with similar but more egalitarian incomes. The life expectancy rates in Japan are not explained only by its economic status nor because the Japanese smoke less and exercise more, but because it is one of the most egalitarian countries on the planet.
Studies have shown that the main reason income inequalities generate a negative impact on health conditions is the decline of the so-called "social capital", that is, the solidarity and trust relations that take place between individuals and groups. According to various authors, the decline of the social capital in inequitable societies greatly accounts for their worse health conditions in comparison with societies where solidarity is more evident. The weakening of social bonds caused by income inequalities incur in low levels of social capital and of political participation. Countries with large income disparities, poor levels of social integration and low political participation are the ones that least invest in the human capital and in social support networks, which are fundamental for the promotion and protection of individual and collective health.

The burden is twofold in Brazil. Besides showing serious inequalities in income distribution, there are strata of the population living in such poverty that they cannot access the minimum essential conditions and goods for their health. Not only is the income of the richest 20 percent of the population 26 times larger than the income of the poorest 20 percent, but also 24 percent of the economically active population earns less than two dollars a day. The subject of poverty has caught the attention of several authors, which has, in turn, produced a change in the way it is understood and combated. For these authors, poverty is not simply the inability to access material goods, but the lack of opportunities and conditions for choosing between different alternatives. Poverty is also a lack of voice in the State and society and a great vulnerability to unforeseen events. Therefore, the capacity of the poor to act upon their health and the health of society is impaired.

In coherence to this new manner of understanding poverty, strategies against it should include both the development of economic opportunities as well as methods that favor the creation of support networks and stimulate an improvement in the ability of these groups to better understand local and global problems. This will strengthen bonds with other groups and improve their organization and participation in collective actions, thus becoming active social actors participating in social life decisions.

Unfortunately, even though these and other important advancements in the knowledge of social determinants of health conditions and health inequities are found in both Brazilian and international scientific literature, they do not lead
to similar progress in the use of this knowledge in the development of health policies in the country.

This occurs, in the most part, due to weak bonds between the production of knowledge and decision-making processes on health policies and programs, which should be based on knowledge and on scientific evidence. The two processes usually develop separately, with different rationales, agents and institutions involved. However, a stronger relationship between health research and health policies, so that equity is better promoted, does not necessarily imply in denial of the importance of politics in the decision-making process in name of a centralizing rationality based on scientific evidence.

Generally, there are no recipes for policies based on objective research results, but a range of options that science helps to delineate. Choosing between one of these options is an essentially political task that involves several actors with different – and often opposing – interests. In order to increase the use of research results in policy decision-making, it is necessary to support the participation of these different actors, especially the ones that are usually excluded from the decision-making process, by reducing the enormous inequalities in the access to information and knowledge between them.

Therefore, there is no conflict between promoting evidence-based policies and increasing social participation in the process. In fact, in order for health policies to serve the public interest and promote equity, the democratic process of determining these policies needs to be strengthened by increasing the number of social actors involved, providing more space and opportunities for these actors to interact and supporting their participation with egalitarian access to relevant information and knowledge.

**The National Commission of Social Determinants of Health – NCSDH**

The Brazilian Government, concerned with the inequities in the health of the population and in the access to public services, created the National Commission on Social Determinants of Health (NCSDH), as part of a worldwide movement first proposed by the World Health Organization (WHO).

In the World Health Assembly of 2004, Lee Jong-Wook, the Director-General of the WHO, suggested the creation of a commission dedicated to
recommending policies and interventions that improve health conditions and reduce inequities. The Commission on Social Determinants of Health (CSDH-WHO) was, thus, created in March 2005, and will be operative for three years.

The CSDH-WHO is a strategic world forum composed by established leaders in politics, science and the civil society. The commission's main goal is to seek equity in health. Moreover, it is in the forefront of a global process of organizing the existing knowledge on social determinants of health in order to support public policies and practices aimed to minimize health inequities.

The following objectives of the CSDH-WHO should be highlighted:

- To systematize evidence collected in previous experiences and develop policies that tackle social determinants of health;
- To stimulate the interchange with the society as to the implementation of actions fighting social determinants of health;
- To determine mid- and long-term goals in order to make health inequalities a central matter for the WHO.

In July 2005, the Pan American Health Organization gathered all American countries in Washington, D.C., and introduced the proposal for the creation of the CSDH-WHO, which, in turn, caused the interest in the matter to grow. After the meeting, the Oswaldo Cruz Foundation (Fiocruz) and the Secretariat of Health Surveillance (SVS) of the Brazilian Ministry of Health began defining an agenda of activities for Brazil, seeking organized social answers for tackling the country’s social determinants of health.

In March, 2006, only one year after the creation of the World Commission, Brazil initiated its participation, launching the Brazilian CSDH.

The CSDH is the result of a four decade-long Sanitary Reform whose major accomplishment was the incorporation, in the Brazilian Federal Constitution approved in 1988, of Article 196, which determines that “health is a right of all and a duty of the State and shall be guaranteed by means of social and economic policies aimed at reducing the risk of illness and the universal and equal access to actions and services for its promotion, protection and recovery.”

In the last few decades, these and other advancements – which resulted in the improvement of social development indexes and the creation of a Unified
Health System based on the principles of solidarity and universal access to assistance – were obtained. However, a large portion of the Brazilian population still suffers with problems that produce important inequities in health, such as unemployment and the lack of access to decent housing, basic sanitation, health services, quality education and a protected natural environment.

Monitoring these inequities and performing a systematic and profound study on the country’s determinants should facilitate the identification of entry points to public policies seeking to fight them. Therefore, in order for these policies to be more effective, it is necessary, on the one hand, to expand the existing knowledge both on the social determinants of health and their existing hierarchies and interconnections and, on the other hand, to facilitate the incorporation of this knowledge on the development and implementation of public policies. These are the most important challenges the CSDH is set out to fight, in order for the construction of a fairer, more egalitarian and humane society.

The Commission’s major lines of action will be the following:

- To improve the quality and the comprehensiveness of sociodemographic data collected by official health information systems in order to facilitate the motoring of social inequalities in health;
- To include the social determinants of health and the consequences of inequity in the training of health professionals;
- To engage health professionals and administrators in the development of public policies that emphasize equity in health;
- To mobilize the civil society for safeguarding equity as a principle for the implementation of public policies;
- To facilitate the dissemination of knowledge on social determinants of health and of information on related rights;
- To create intersectoral fora for debating and establishing commitments for tackling the problem, including discussing models for short-, mid- and long-term policies;
- To stimulate the expansion of the existing knowledge base on social determinants of health by financing research and supporting the training of researchers;
- To include explicit goals for the decrease in social inequities in health in social policies;
- To interact with other public initiatives for reducing poverty and health risks such as the National Council for Economic and Social Development, the “Zero Hunger” program, the National Council of Food and Nutritional Safety, among others;
- To assure and stimulate actions that tackle social inequalities in health in Brazil in the municipal, state and federal governments, and in the executive and legislative branches;
- To incorporate actions that reduce inequities in health in the budgets of the municipal, state and federal governments.