# Challenges, consequences, and possible paths for confronting post-COVID-19 health inequalities and vulnerabilities

## *Desafios, consequências e possíveis caminhos para o enfrentamento das desigualdades e vulnerabilidades em saúde pós-Covid-19*

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**ABSTRACT** The article aims to discuss the challenges and consequences of health inequalities and vulnerabilities, focusing on current phenomena that have reshaped such context, namely financial crisis, fiscal austerity, and the COVID-19 pandemic. Differences between levels of access to wealth and opportunities among and within countries belonging to different income groups create and perpetuate social inequalities that frequently become health inequities. It is challenging to understand both the recent changes and the persistence of inequalities and social stratification, and the issue has thus taken on new dimensions that extrapolate studies focused exclusively on income distribution. The financial crisis, fiscal austerity, and the COVID-19 pandemic have aggravated preexisting health inequalities. Thus, the issue of inequalities in health should be an intrinsic part of public policy, with clear and stable standards and objectives based on explicit political agreements and a legal framework with sustainability ensured by an adequate financing policy. Only then will it be possible to achieve greater levels of equity, even in the face of dramatic situations such the one now faced by the world.

**KEYWORDS** Health status disparities. Health vulnerability. Sustainable development. COVID-19. Health policy.

**RESUMO** *O texto teve por objetivo discutir os desafios e as consequências das desigualdades e das vulnerabilidades em saúde, trazendo para discussão fenômenos atuais que vêm reconfigurando esse contexto – crise financeira, austeridade fiscal e pandemia da Covid-19. As diferenças nos níveis de acesso à riqueza e a oportunidades, presentes entre e dentro dos países de distintos grupos de renda, criam e perpetuam as desigualdades sociais, que, muitas vezes, tornam-se iniquidades em saúde. Compreender as recentes mudanças e, também, as permanências, no que se refere às desigualdades e à estratificação social, é desafiador, o que fez com que o tema adquirisse novas dimensões que ultrapassaram os estudos centrados exclusivamente na distribuição de renda. A crise financeira, a austeridade fiscal e a pandemia da Covid-19 agravaram as desigualdades em saúde já existentes. Assim, a questão das desigualdades na saúde deve ser intrinsecamente parte da política pública, com normas e objetivos claros e estáveis, baseados em acordos políticos explícitos e em uma estrutura legal, com sua sustentabilidade assegurada por uma política de financiamento adequada. Somente dessa forma, será possível alcançar maiores níveis de equidade, mesmo diante de situações dramáticas como a que se vive.*

**PALAVRAS-CHAVE** *Disparidades nos níveis de saúde. Vulnerabilidade em saúde. Desenvolvimento sustentável. Covid-19. Política de saúde.*

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## Introduction

The perception that health and therefore disease are produced and distributed unequally in populations is not a new one, creating what we now call 'health inequalities'. Intuitively, one cannot deny the harmful effects on individual and community health from environmental degradation, inequalities in the distribution of income and power, weaknesses in work conditions and educational and health systems, political crises, and, more recently, prejudice related to gender, ethnicity, and sexual orientation, among others.

Importantly for this discussion, such inequalities frequently become health inequity, a difference produced in health by the position that individuals occupy in society and that places some groups at a disadvantage in relation to the opportunity to be healthy and to remain so. Thus, inequalities define relationships based essentially on power and access to and possession of goods, services, and wealth. Consequently, the fruits of social labors accumulated over the course of generations are distributed unequally, giving rise to groups with greater social vulnerability.

This critical and reflexive paper aims to discuss the challenges and consequences of health inequalities and vulnerabilities, focusing on current phenomena that have reshaped such context, namely financial crisis, fiscal austerity, and the COVID-19 pandemic. At the end, readers will be invited to reflect on possible paths to reduce inequality.

## Health inequalities and vulnerabilities

The most visible face of inequality is the existence of people with different levels of access to wealth and opportunities. This is seen in the four groups of national income (high, upper-middle, lower-middle, and low). According to the 2019 Human Development Report published by the United Nations Development Program[1], income inequality in favor of the wealthiest tenth of the population has increased since 1980 in most regions of the world, but at different paces and with distinct levels. In 2015, the last year with available data, inequality was extremely high in Sub-Saharan Africa, Brazil, and the Middle East, where the wealthiest tenth held 55% to 60% of total income in countries or regions. These extreme levels of inequality in low- and middle-income countries deserve special attention.

More recently, the exacerbated inequalities between countries have intensified human migratory flows, evidencing that place of birth is another important determinant of inequalities. As an essentially complex social phenomenon with multiple determinants, migration is closely related to the history and overall development process of nations, leading populations of poorer countries to turn to emigration to seek access to centers with greater economic dynamism and social welfare. The wave of migrations tends to have diverse consequences, both a shortage of labor in countries of origin and political crises and racist backlash in countries of destination. Restrictive immigration policies through detention, reduced access to social services, among others, not only harm the migrants' health but fundamentally undermine human rights in general[2].

In relation to inequalities within nations, structural factors carry greater weight by reproducing mechanisms of exclusion that adapt over the course of history. In countries with heavy income inequality, the association between parents' and children's income is stronger, that is, income mobility between generations is weaker. In Denmark, a country with a more favorable situation, estimates indicate that approximately two generations are necessary for members of a low-income family to rise to middle income, while the estimated time in Brazil is nine generations[3].

This relationship does not imply direct causality, but it can be understood based on inequality. Inequality decreases mobility because

it shapes opportunity. In more unequal territories, for example, there are fewer opportunities, incentives, and institutions that form, develop, and transmit characteristics and skills valued by the labor market, and there is no balance of power for some groups, especially more vulnerable ones, to occupy positions involved in structuring policies. Factors related to inequality of opportunities include family background, gender, race, and place of birth in the territory, all heavily related to income inequality[1].

Based on the proposal for evaluation of the combined effects of inequalities among and within countries, the concept of global inequality was reported more recently by Milanovic[4] as an approach to the age of globalization and given the availability of international data. Global inequality is the result of inequalities among and within countries and is thus defined by the interaction between the respective determinants.

The goal of research on global inequality is not merely to describe the changes, but to learn about their political implications. For example, the global Gini index is higher than the index in countries with the highest levels of social inequality, indicating an even greater international gap compared to the intranational gap. In recent years, the countries with the highest levels of inequality showed Gini coefficients around 0.60, while the global Gini index is close to 0.70. This difference is due to the global Gini coefficient's capacity to capture the extremes in the poorest strata of the poorest countries and the wealthiest strata in the wealthiest countries, pointing to an even higher level of inequality than when each country is measured separately[5].

The global inequality approach is consistent with the discussion by experts who signal the urgency of understanding the determinants and their connections dynamically, as they occur in a globalized world. Social inequalities in health are a global problem that affects all human societies to a greater or lesser degree. Thus, the investigation of social determination in complex contexts through a narrow representation of social vulnerability (captured only by one social dimension, associated with a single health indicator) is over-simplified and disguises the web of determinants involved in such contexts.

To illustrate the interconnections between determinants, let us assume that children's schooling depends on their parents' socioeconomic status, which is also related to the children's health, beginning even before birth, and cognitive capacity, through stimuli throughout early childhood. This set of attributes also heavily influences the possibility of growing up in a neighborhood with adequate sanitation conditions, the schools these children will attend, and the opportunities they may have in the labor market. We should also consider the children's race and gender and their affective networks. All these factors determine the health of those children who, in the presence of deficits, may have their capacities jeopardized for generating income and participating in their communities' social and political life. All those deprivations can reinforce each other and accumulate over time, generating and even expanding social disparities.

The relationship between life expectancy and schooling, for example, points to huge differences within the same country. Individuals that have received less schooling present disadvantages and lower life expectancy compared to those with more schooling. This difference varies, in turn, between countries and is smaller in countries like Canada and New Zealand and much higher in Hungary, Poland, and Czech Republic. The findings show that even among countries in Eastern Europe and among member nations of the Organization for Economic Cooperation and Development (OECD), there are important disparities between living conditions and their impacts on inequality in health[6].

The fight against inequalities has gained space on the global agenda, especially since 2005 with the creation of the Commission on Social Determinants of Health by the World

Health Organization (WHO). At the end of its term in 2008, the Commission delivered a final report that emphasized the importance of action on social determinants to reduce inequities in health, both among and within countries, over the course of a generation.

In October 2011, invited by the WHO, heads of government, ministers, and government representatives met in Rio de Janeiro to reaffirm their commitments to promote social and health equity through actions on the social determinants of health and well-being, implemented through a wide inter-sector approach. The document 'Rio Political Declaration on Social Determinants of Health'[7] from 2011 summarizes the following commitments: a) to improve daily living conditions, the circumstances in which people are born, grow up, live, work, and age; b) to tackle the inequitable distribution of power, money, and resources, the structural drivers of the above-mentioned living conditions, at the global, national, and local levels; and c) to measure and understand the problem and assess the impact of action, expand the knowledge base, develop a body of trained human resources in the social determinants of health, and raise public awareness on the theme[7].

With the purpose of reinforcing these commitments and proposing clear and practical measures to implement sustainable development, the city of Rio de Janeiro also hosted, in June 2012, the United Nations Conference on Sustainable Development, or Rio + 20. In that conference, the important decisions by the Member States feature the launching of a process to develop a set of goals to unify the commitments to social development and the sustainability agenda, which converged in the post-2015 development agenda, the 2030 Agenda; provision of innovative guidelines on policies for a green economy; establishment of an intergovernmental process under the General Assembly to prepare options for a strategy to finance sustainable development; strengthening of the United Nations Environment Program on various fronts; and the establishment of a high-level political forum on sustainable development[8].

## Challenges for stratification of health inequalities

It is challenging to understand the recent changes and the persistence of inequalities and social stratification. The multiple facets of inequalities and their complexity and dynamism over time have given the subject new dimensions that extrapolate studies focused exclusively on income distribution, spawning increasingly frequent studies on stratification of inequalities based on attitudes, identities, and symbolic frontiers between social groups. Thus, more complex conceptualizations are needed, considering four pillars that can be reflected in the context of health: 1) inequalities in 'what'; 2) inequalities between 'whom'; 3) inequalities 'when'; and 4) inequalities 'where'[9].

An understanding of inequalities requires expanding one's view beyond inequalities of chances or opportunities, which would assume that individuals have similar social opportunities and that the disparities in their living conditions reflect differences in individual effort, when we know for a fact that other aspects are involved in that context, such as gender, race, and ethnicity. Thus, avoiding the liberal ideology of meritocracy, according to which social positions result from personal achievements rather than from social ascriptions, research on inequalities has grown, focusing on the study of inequalities of position or outcome[9].

The contemporary discussion on 'inequalities between whom' becomes even more complex. Such binary categories as white/black, female/male, citizen/foreigner, and Christian/Muslim are not sufficient to understand the structuring of inequalities. Some categories overlap: for example, when we think of citizen and foreigner, it is possible to use a multiple categorization such as the immigrants' legal status, gender, and country of

origin. A study in 2016 in Portugal with 682 Brazilian immigrants who had lived in that country for more than three months found a high unemployment rate and poor quality of life[10]. A review by Corro and Arredondo[11] of 239 articles on the use of health services by Mexican migrants in the United States found that beyond socioeconomic status, the different forms of healthcare access depended on immigration status. Such interactions indicate the possibilities for access to the welfare state, giving rise to important inequalities, including in health, which affect different groups of 'foreigners' within the same country.

In this context, based on the understanding that inequalities stem from positions in social structures which derive, in turn, from complex interactions of categorizations of race, gender, class, and others, the view of intersectionality emerges. For example, gender issues have been discussed extensively in recent years, and given the evidence of women's low participation in local and global health, many initiatives have been consolidated such as the WHO Global Strategy on Human Resources for Health; the 2030 Task Force; the United Nations High-Level Commission on Employment and Economic Growth; the 50/50 Global Health Reports; Women in Global Health; and #LancetWomen. In addition to gender parity, there is a concern for recognition that women constitute heterogeneous groups and that the privileges and disadvantages that allow and prevent progression in their careers cannot be reduced to a shared universal experience, explained only by gender. Rather, it is necessary to consider the ways by which gender intersects with other social and stratifying identities to create unique experiences of marginalization and disadvantage[12].

In relation to the third pillar, namely 'when' inequalities occur, epidemiological surveys reveal persistent health inequalities, but also inequalities that vary over the course of history. When we consider ethnic inequalities in Latin America, some key studies have sought to reconstruct the nexus between contemporary inequalities and the region's history, shaped by external and internal colonialism and slavery[9]. As during colonialism, black and poor Latin Americans still have the least access to essential goods and services to guarantee health. In the 20 largest cities of Brazil, the black and low-income population has less access to opportunities in work, health, and education[13].

The fourth pillar, our understanding of 'where' health inequalities are established has also changed over time. Intense globalization allows continuous exchange of persons and merchandise and has made increasingly evident that studies in overly circumscribed contexts fail to fully grasp all the determinants of health inequalities, which require approaches that seek to expand the scope of investigation to capture the transnational and global interdependencies that shape the local and national structures of inequality.

Studies of health inequalities have thus begun to incorporate a variety of new perspectives into the scope of investigation, alongside the elements classically studied on inequalities and stratification, called the 'usual suspects'. In this movement, studies have emerged on perceptions, values, and notions of social justice; studies on the elites, not only economic, but political, cultural, and intellectual; studies on generations, territory, and urbanism; economic and development policy; and the effects and consequences of inequalities on crime, violence, and interpersonal trust[14].

## Financial crisis and fiscal austerity: increase in inequalities and their effects on health in the world and in Brazil

The financial crisis of 2008 in Europe and the fiscal austerity measures implemented in various countries, characterized by the implementation of fiscal adjustment policies with an emphasis on controlling expenditures, aimed

at rebalancing public accounts and promoting rapid economic growth, led to negative effects on the health of populations. Vieira and Benevides[15], in a review of studies on the crisis in high-income countries and their lessons for Brazil, showed that economic crises can aggravate existing social problems and increase inequalities, worsening the population's health status. Meanwhile, fiscal austerity measures, by establishing a reduction in spending on social protection programs, tend to aggravate the effects of the crisis on health status and particularly on social conditions in general.

The effects of the economic crisis and fiscal austerity policies on the health of high-income countries have been described extensively in the scientific literature. Paes-Sousa et al.[16] reviewed studies, especially in countries of the Northern Hemisphere, addressing the effects of austerity on health risks, the epidemiological profile, and health systems and services from 2006 to 2017. They observed a worsening of indicators of mental disorders (suicide, suicide attempts, and depression), infectious diseases (HIV, tuberculosis, malaria, and Nile fever), noncommunicable diseases (cardiovascular diseases), and childhood diseases (asthma and domestic accidents).

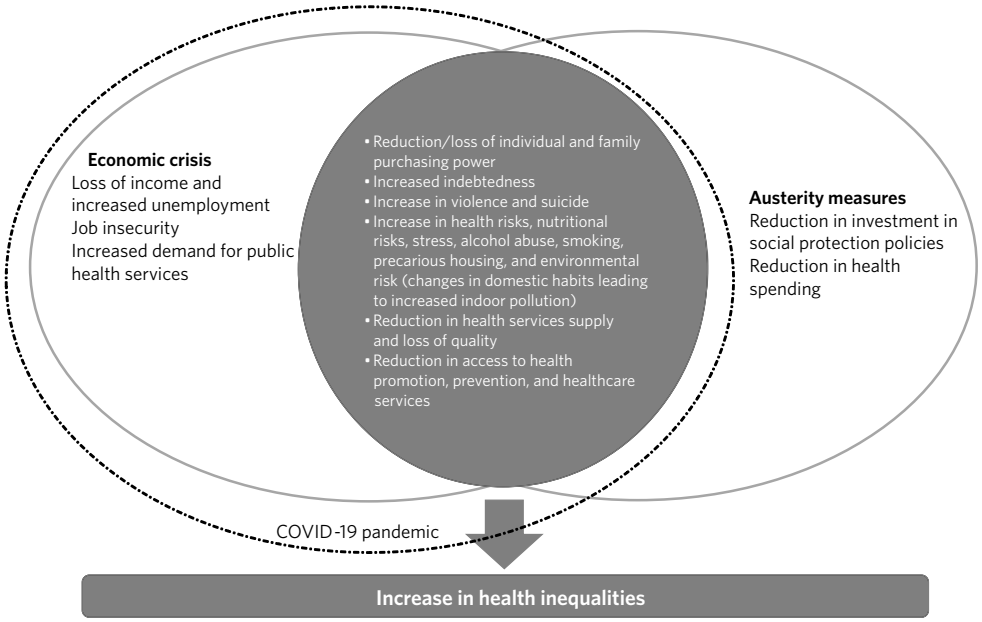
According to the authors, the growth of poverty directly impacts the incidence of such diseases, with a resulting increase in exposure to risks of infection and stress related to shortage of income from work or social transfers. In relation to social factors, the authors highlight the increase in unemployment, increasingly precarious work conditions, loss of health insurance, fear of loss of jobs and its consequences (reduced quality or loss of housing and reduced food consumption).

Paes-Sousa et al.[16] also identified a major reduction in health spending. The health sector was affected in countries with national health systems such as the United Kingdom and Sweden; national social security systems such as Germany and Japan; and private insurance systems such as the United States and Australia. The United States experienced a significant reduction in access to health services due to unemployment and a resulting reduction in health insurance, besides a decrease in donations to charitable medical services. The overall reduction in spending led to a reduction in financing for health promotion, prevention, and healthcare and in investment in research and development. Thus, studies point to a reduction in the services provision network, human resources, and inputs in various countries. The effects of scarcity had repercussions on the quality of the services provided, affecting the administrative and management capacity and quality of the services.

For individuals and families, the combination of the reduction in income due to unemployment and the reduction of social transfers affected the habits and attitudes of the poorer populations and their relationship to health risks and healthcare. Many countries experienced diet changes and increased stress. The reduction or imminent reduction of purchasing power altered the search for health services, with the postponement or suppression of the search for those services because of the reduction in family spending, or as a way of avoiding the stigma of weak health and thus propensity to inclusion in priority groups for job layoffs[16].

The combination and feedback between economic crisis, austerity policy, and now the crises caused by the COVID-19 pandemic (besides the economic, health, and humanitarian crisis) have negative consequences for various dimensions of life, thereby increasing health inequalities (*figure 1*).

Figure 1. Combined effects of the economic crisis, fiscal austerity measures, and the COVID-19 pandemic on health




Source: Prepared by the authors based on Paes-Sousa, Schramm, & Mendes[16].

Brazil entered a crisis in 2014, when the Gross Domestic Product (GDP) interannual growth rate was 0.46%. Despite the positive variation, starting in the second quarter of that year there were successive drops in GDP, with the country entering an economic recession. Reductions in GDP were also seen in 2015 (-3.15%) and 2016 (-2.93%). In 2017, Brazil again showed positive variation in its GDP (0.99%)[17]. This scenario was altered by the COVID-19 pandemic.

The prolonged economic crisis can be expected to have a catastrophic effect on Brazil's social indicators. The analysis of the historical series on poverty and extreme poverty that began in 1992, published by the Brazilian Institute of Geography and Statistics (IBGE), based on data from the National Household Sample Survey (PNAD), points to a major reduction starting in 2003, when 41.8 million and 12.9 million Brazilians were living in situations of poverty and extreme poverty, respectively. The poverty indicator showed the best performance in 2014, when 14.1 million Brazilians were in this situation, while extreme poverty was at the second lowest level in history with 5.2 million Brazilians. Both indicators were significantly impacted by the crisis and austerity policies starting in 2015. In 2017, more than 20 million Brazilians were in poverty and 11.8 million in extreme poverty, the highest numbers since 2004[18].

The growth in unemployment, which according to IBGE[19] reached 13% in 2017, is one of the factors that helps explain the increase in poverty. Budget cuts in social programs such as the National School Food Program (PNAE) and significant cuts in others such as the Cisterns Program and the Food Purchases Program, which suffered budget cuts of 90% and 99%, respectively, also directly affected Brazilian families' socioeconomic conditions[20]. Although the introduction of emergency aid as a strategy to mitigate the perverse effects of COVID-19 on families' income produced a momentary reduction in poverty, the strategy is unsustainable in the long run, and a major share of the population can be expected to fall back into poverty as soon as access to the benefit is over, due to the return to fiscal austerity policy.

The most alarming consequences of this scenario include the increase in neonatal and infant mortality rates in 2016. The under-five mortality rate in Brazil, which had been falling consistently since 1990, increased from 15.8 deaths per thousand live births in 2015 to 16.4 in 2016. A similar pattern was seen in the infant mortality rate (under one year of life), which increased from 13.3 deaths per thousand live births in 2015 to 14 deaths per thousand live births in 2016. The under-five and infant mortality rates increased in all major geographic regions of Brazil except the South, where they continued to fall[20].

Brazil's fiscal austerity policy was suspended temporarily during the COVID-19 pandemic, having been produced in response to the crisis in 2016 and implemented since 2017. Constitutional Amendment 95, which provides the legal backing for austerity, limited the increase in public spending to the inflation rates[15], further exacerbating the preexisting budget deficit in public health in Brazil and extending out to 20 years, an unprecedented policy in global history.

Rasella et al.[21], drawing on data from the Bolsa Família Program, the Family Health Strategy, the poverty rate, and the possible effects of Constitutional Amendment 95, estimated that Brazil's under-five mortality rate will be considerably higher under this amendment when compared to maintenance of the current levels of social protection, leading to a potential 8.6% increase in the infant mortality rate by 2030. The authors further estimated that maintenance of the coverage by the Bolsa Família Program and Family Health Strategy would reduce avoidable deaths by nearly 20 thousand and up to 124 thousand avoidable pediatric hospitalizations between 2017 and 2030[21].

Although fiscal responsibility is essential for maintaining macroeconomic stability, austerity measures in social investment are provenly flawed. First, because the studies behind their assumptions are weak, while there is robust evidence in the opposite direction, namely that cuts in spending on social protection policies delay the resumption of economic growth[22]. Second, because the social costs of implementing austerity measures are extremely high, reinforcing the negative consequences of the crisis, leading to increased poverty, social inequality, health risks, and morbidity and mortality. Economic policies that opted for fiscal austerity as a way to confront the crisis were the same ones that had the greatest restrictive impact on health systems and services[19]. It is thus recommended to preserve social protection programs to mitigate the negative social consequences of the economic crises that are certain to add to the pandemic's effects.

## The context of the COVID-19 pandemic and its short and middle-term effects on health inequalities

Since 2020, the entire planet has experienced the worst health and humanitarian crisis of this century. Notified for the first time in December 2019 in Wuhan, China[23], the novel coronavirus quickly spread throughout the globalized world, causing thousands of deaths and with consequences that are still not entirely known.

According to the most recent estimate by the Institute for Health Metrics and Evaluation, 18.2 million persons had died from COVID-19 by December 31, 2021, three times more than official records suggest[24]. Besides the direct and indirect deaths, the pandemic's consequences include an increase or exacerbation of other diseases due to health services' interruption or problems accessing them[25]. The mitigation measures such as physical distancing have also led to increased stress, anxiety, and depressive symptoms, with a possible crisis in the mental health area as well[26].

Pandemics such as the one gripping the world today are biological, environmental, and social phenomena with heavy economic and political implications. Despite the high transmissibility of the novel coronavirus, there is no doubt that the rapid spread of COVID-19 around the world was determined by the globalized way of life. This includes the integration of the world's economies, which allowed a major increase in

the circulation of persons and goods, promoted the intensive and unsustainable use of natural resources, and accentuated social changes that favor contagion from infectious diseases, such as intense urbanization, mass mobility of populations in these spaces, and agglomeration of major contingents of poor people occupying precarious housing with limited access to basic sanitation[27].

The observed variations between countries in mortality rates from COVID-19 are explained partially by demographic data, including population density, proportion of persons 80 years old or older, urban population, and GDP growth[28]. However, some countries show evidence of social and ethnic disparities in the burden of COVID-19[29,30].

The determinants of inequality in COVID-19 deaths include ethnic, racial, and socioeconomic inequalities[31-33]. Excess mortality from COVID-19 in the black population in Detroit, Michigan, highlights the relationship between racism, poverty, and health. Racism and socioeconomic disadvantage show evident and persistent, significant, and multifaceted associations with health problems, thereby replicating historical patterns[34].

In Brazil, a country structured by racism with persistent roots in colonial slavery and a historical process that has determined persons' social places according to race or ethnicity, the black population has suffered more severely from the pandemic's impacts and its various negative outcomes. Despite the precarious information, we know that most of the population living in precarious areas and in situations of extreme poverty are blacks, proportionately twice as many as whites[35].

There has also been an important difference in COVID-19 mortality between Brazil's five major geographic regions, with the highest rates in the poorest regions and with the greatest deficiencies in healthcare services, namely the Northeast and North when compared to the Southeast, Central-West, and South[36].

In addition to the inequalities in COVID-19 mortality, the risk of SARS-CoV-2 infection is also distributed unequally. Factors that help explain the difference in risk of infection include more persons per household, children attending schools and other educational facilities in person (except for primary schools), attendance at professional or private events, attendance at bars and restaurants, and participation in indoor sports[37], besides low socioeconomic status[38].

Most national governments have reacted to the pandemic with restrictions on mobility to contain the spread of infection[39]. However, the type of employment and level of financial necessity may increase exposure to the virus for individuals living in disadvantaged socioeconomic conditions[40]. Partial or total telework is known to be associated with a reduction in risk of infection[37], but certain occupations do not allow adherence to home-office work, which contributes to the risk of additional exposure for those workers[39,40]. Socially disadvantaged individuals are also more prone to rely on public transportation for their mobility, posing a significant risk for spread of SARS-CoV-2[41].

Growing evidence shows that socially disadvantaged populations face various barriers to a healthy life, including limited capacity to adhere ideally to COVID-19 risk mitigation measures. Hagan et al.[42] analyzed a representative sample of American adults with cardiovascular disease and found that individuals with a higher burden of social determinants of disease are less likely to adhere to COVID-19 risk mitigation strategies such as personal protection, social distancing, and flexible work hours.

Although closing bars, restaurants, and informal commerce and restriction of industrial production contribute to containing the pandemic, they result in layoffs and reduction in the workforce and will lead to post-pandemic underemployment and unemployment[41]. Economists predict that unemployment and inflation will translate as increased poverty and lower living standards in the population after COVID-19[43].

Although the Brazilian government approved some emergency COVID-19 aid during

the pandemic (a benefit to guarantee minimum income for Brazilians in situations of greater vulnerability during the pandemic), the effects of slower economic activity exacerbate the country's existing social inequality, preventing this population from adhering adequately to restrictions on mobility.

The challenges for confronting the pandemic are thus numerous and complex. For interventions to be more effective and to protect especially the more vulnerable population, they should thus tackle social inequality to achieve equity in health.

## Strategies to reduce health inequalities and vulnerabilities

Inequalities, which generate vulnerabilities (both existing or emerging), require a public policy approach that protects individuals from this unfavorable context. This translates as the expansion of access by these individuals to a range of public (and private) goods and services for them to be able to share a social life with equality of rights. Overcoming these deficits means developing specific policies for these individuals to achieve a threshold of citizenship that ensures more equal conditions. This essentially requires progress in public policy approaches, moving from a context in which specific sector systems work in isolation to crosscutting and inter-sector linkage in complex programs. Therefore, addressing health inequities aims to move out of the closed health system and to link with other social policy and social protection systems.

A comprehensive approach to the fight against health inequality, according to Paes-Sousa, Buss, and Barreto[5], should necessarily consider three lines: 1) to develop a distinct health policy goal; 2) to intervene in the social determinants of health inequalities; and 3) to improve living conditions and overcome mechanisms of exclusion related to barriers to access to health systems. *Figure 2* illustrates these lines and their specific strategies.

Figure 2. Strategies for the reduction of health inequalities and vulnerabilities


Source: Prepared by the authors based on Paes-Sousa, Buss, & Barreto[27].

There is thus an undeniable need for investments in the set of social policies that are potentially associated with the promotion of more equitable health conditions – policies in education, labor, and social protection and gender and housing policies. Such policies are thus frequently present in national commitments. However, the main challenge is to transform these commitments into effective policies.

Despite evidence backing the implementation of measures to intervene in the determinants of health inequalities, policies to mitigate

these inequalities at the national and international levels have rarely been implemented. The difficulties are even greater for low- and middle-income countries. Brazil made important strides in social protection, education, health, and social housing. However, the possibility of setbacks to those strides is real, through cuts in public spending in these areas and the dismantlement of various social policy systems since 2016.

In the current international scenario, the 2030 Agenda provides the most relevant global platform for overcoming inequalities between and within countries, including in the field of health. With the central thrust of 'leaving no one behind', as in the general call by the United Nations to the Member States, the 2030 Agenda declared the effort to overcome health inequalities through Sustainable Development Goal 3: 'Ensure health and promote well-being for all at all ages'. However, the means of implementation presented in Sustainable Development Goal 17 appear to be insufficient to meet the implicit demand in such an ambitious proposal.

The gap between the stated health goals and the means of implementation is perhaps the 2030 Agenda's main weakness. The goals implementation will thus depend on the political will of the entire society – executives, legislators, judiciary, and civil society – in the form of national development plans, conceived as a strategy for sustainable development[5].

The Sustainable Development Goals Report 2020[25], which compiles the most recent data for monitoring the 2030 Agenda, showed that before the COVID-19 pandemic, progress remained irregular and still far from the path to meeting the targets by 2030. Some gains were considerable: the number of children and youth out of school had fallen; the incidence of many communicable diseases was declining; access to safe drinking water supply had improved; and women's representation in leadership positions was increasing. However, the number of people suffering from food insecurity was increasing, the environment continued to deteriorate at an alarming rate, and dramatic levels of inequality persisted in all regions. Thus, the change was still not happening at the necessary pace or on the required scale. Currently, due to the COVID-19 pandemic, an unprecedented synergy of crises (health, economic, and social) is threatening lives and means of subsistence, making it even more challenging to reach the targets.

Therefore, the fight against health inequalities should be an intrinsic part of public policies with clear and stable standards and goals based on explicit political agreements and a legal framework with sustainability ensured by an adequate financing policy. Only then will it be possible to achieve greater levels of equity, even in dramatic situations like the one faced by the world today.

## Collaborators

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