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Addressing health inequalities in Latin America: the role of social protection

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Abstract *After more than a decade of progress in various areas of social development, since 2015 poverty has increased, labor market indicators have deteriorated, and the reduction of income inequality has stagnated in Latin America. These trends are of concern as they can affect health indicators and exacerbate profound health inequalities. This situation demands integrated policy responses that can create synergies between different sectors. There is growing recognition of the role of social protection in the eradication of poverty and the reduction of inequality. Various social protection mechanisms buffer against the costs of accessing health services directly and indirectly. By expanding coverage and universal access, promotion and prevention actions in health and nutrition, and fundamentally, the fight against poverty, inequality, and exclusion, social protection plays a fundamental role in guaranteeing the right to health and overcoming inequalities in this area. The reduction of inequalities in health should be a priority for all countries, and a way forward in that direction is to promote the construction and strengthening of universal social protection systems.*

Key words *Inequality, Health, Social protection, Latin America*

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Introduction

Inequality, in its various expressions, is a major structural problem in Latin America. After more than a decade of progress in various areas of social development in the region, , including declining poverty, income inequality and higher social and labor inclusion, since 2015 the region has experienced an increase in poverty rates (in particular, extreme poverty), higher levels of unemployment, a deterioration in employment quality indicators, and stagnation in the reduction of income inequality. These trends are also of concern from the perspective of health inequalities since they can directly or indirectly undermine health and nutrition indicators and exacerbate the existing deep gaps in this area. In turn, the setbacks in health indicators and growing health disparities contribute to propagate a vicious cycle of poor health, poverty, and inequality. In this scenario, it is imperative to strengthen and expand social protection systems and promote redistributive policies to mitigate the negative impacts of this process on the well-being of the population and develop measures that promote their full social and labor inclusion and the full right to health. This paper aims to show evidence on health inequalities in Latin America and its recent trends and reflect on the role of social protection to reduce these inequalities.

The recent trend of poverty and income inequality in Latin America

The eradication of poverty and extreme poverty, as well as the reduction of inequality in all of its manifestations, are great challenges for Latin American countries. In the 2002-2014 period, the region made notable progress in these areas and other social indicators, such as education and health indicators. The achievements of decreasing poverty, extreme poverty, and income inequality in that period were associated with positive trends in the labor market (in particular declining unemployment, increasing work formalization and improved labor income) and the expanded and strengthened social protection systems. Starting in 2015, setbacks are recorded: poverty and extreme poverty rates jump from 27.8% and 7.8% in 2014 to 30.2% and 10.2% in 2017[1], respectively.

This scenario takes place in a context of weak economic growth and fiscal restrictions, with higher unemployment rates and labor informality, and ignites warning signs of its possible negative impacts in the short and long term on the well-being of the population[2]. Likewise, significant inequalities are found in the incidence of poverty and extreme poverty by gender, age, ethnic-racial status, and area of residence. This situation is more severe in people living in rural areas, children, adolescents, and young people, indigenous people, people of African descent, women of productive age, and people with lower education levels[1]. Rural populations and children, adolescents, and young people also registered an increased incidence of poverty between 2012 and 2017[1].

Income inequality fell significantly between 2002 and 2017 (the Gini index declined from 0.53 to 0.47). However, this decline attenuated between 2014 and 2017, and high levels of inequality persist, setting Latin America as the most unequal region in the world[1]. The narrowing gaps between the groups of lower and higher resources were primarily due to improved labor income in the lower-income strata. Moreover, pensions and transfers played an important role, particularly in the lower-income strata[1].

Beyond income inequality

Inequality is a historical and structural characteristic of Latin American societies and includes economic or means inequality (income, property, financial and productive assets), inequality in the enjoyment of rights, capacity development, access to opportunities, autonomy, and reciprocal recognition[3]. The concept of the "social inequality matrix" (Chart 1) contributes to advancing the analysis and reflection of this complex, multidimensional, and multi-causal phenomenon to guide policies for its reduction. One of the contributions of this concept is that it proposes an approach to inequality that considers the confluence of multiple and simultaneous forms of discrimination and exclusion and how these result in health inequalities and other areas of social development, which, in turn, mutually reinforce each other.

The social inequality matrix is conditioned by the matrix or productive structure of the region, which concentrates employment in informal and low-quality jobs, with low income and limited or no access to social protection mechanisms. The labor market links a heterogeneous productive structure (and inherently unequal concerning productivity, access, and quality of jobs) with marked income inequality in households. The social inequality matrix is also conditioned by

Ciência & Saúde Coletiva, 25(5):1587-1598, 2020

Chart 1. Social inequality matrix.

Theoretical approaches	Structuring axes	Areas of rights that are affected
. Structural heterogeneity (productive matrix) . Culture of privilege . Concept of equality: - Equal means (income and productive resources) - Equal rights - Equal capacities - Autonomy and reciprocal recognition	. Socioeconomic level . Gender . Race and ethnicity . Life cycle stage . Territory . Disability . Migratory status . Sexual orientation and gender identity	. Income . Work and employment . Social protection and care . Education . Health and nutrition . Essential services (water, sanitation, electricity, housing, ICT) . Citizen security and a life free of violence . Participation and decision-making

Source: CaribeEconomic Commission for Latin America and the Caribbean (ECLAC), Towards a regional agenda for inclusive social development: Bases and initial proposal (LC/MDS.2/2), Santiago, 2018[4].

the culture of privilege, a historical feature of Latin American and Caribbean societies, which naturalizes social hierarchies and marked asymmetries of power and access to productive assets, and that has a system of rules, practices, and institutions that do not ensure equal opportunities and treatment. The culture of privileges is based on the denial of the other as a subject of rights. To that extent, it establishes and reproduces economic, political, social, and cultural privileges associated with the ethnic-racial, gender, origin, culture, language, and religious status of the people and social groups[5].

The first axis of the social inequality matrix is the socioeconomic stratum, whose central elements include the structure of ownership and the distribution of resources and productive and financial assets. One of its most apparent and most obvious manifestations is income inequality, which is also the cause and effect of other disparities in areas such as health, access to primary services, and education[3]. However, other axes structure social inequalities in Latin America: gender, ethnic and racial status, territory, life cycle stage, disability status, migratory status, and sexual orientation and gender identity (Chart 1). What gives each of these axes the structuring character in the configuration of social inequalities is their constitutive and decisive weight in the process of production and reproduction of social relationships and the subjective experience of people or, in other words, its impact on the magnitude and reproduction of inequalities in different areas of development and the exercise of rights[3].

The structuring axes of the social inequality matrix intersect, strengthen and accumulate throughout the life cycle, which generates a multiplicity of inequality or discriminatory factors that interact simultaneously and accumulate over time and generations[3].

Health implications

Incontrovertible evidence regarding the relationship between the axes of the social inequality matrix and health inequalities has been documented. From the seminal studies of Whitehall, a pronounced inverse association between social class, measured by occupational category, and mortality from a wide range of diseases has been identified[6]. Evidence indicates that the level of household income influences the health status of its members through the consumption of healthy food, housing quality, risk behaviors, access to quality health services, and less tangible factors, such as social capital. On the other hand, direct associations are found between continual exposure to discrimination based on race and ethnicity and a wide range of mental disorders and physical health conditions[7]. Finally, and in line with the concept of the social inequality matrix, experiencing the multiple and simultaneous forms of inequality associated with its structuring axes, which interact and amplify each other, shapes life experiences and realities that result in health inequalities that must be addressed in an integrated and holistic way.

Health inequalities, both in access and outcomes s, not only reflect the violation of the right to health, which also affects the enjoyment of other rights, but are also a central link for the reproduction of poverty and inequality, by reduc-

ing capacities and opportunities in the economic sphere, hindering innovation and productivity gains. People with good health and nutrition have better physical and mental abilities for work, as well as lower rates of work absenteeism. Health also has an indirect effect on productivity by facilitating cognitive development, learning capacity, and school performance, as well as the possibility of learning and acquiring new skills[5]. Therefore, guaranteeing the right to health and reducing the gaps observed in this area are fundamental elements both for the eradication of poverty and the reduction of inequality and for economic growth and sustainable development.

Health inequalities: some indicators

Significant advances have been made over the last decades in the health status of the population of Latin America, which currently lives longer and healthier lives than before. However, that progress has been uneven, and millions of people have been left behind. Health inequalities are evident in marked differences in access to services for the prevention, detection, and treatment of health conditions, segmentation in the quality of these services, and, ultimately, health outcomes. Considering the current tools, resources, and technological advances in the field of health, good health should be available to all, and health inequalities are not acceptable.

The scenario of inequality that characterizes the region is expressed, for example, in the relevant health inequalities that affect indigenous and African-descent children, which are not only a severe violation of their rights but also have consequences for later stages of the life cycle[8,9]. Infant mortality (which occurs before the first year of life) is an indicator that reflects the inequalities that affect indigenous and African-descent children in Latin America since the beginning of life (Graph 1). To address them, it is necessary to adopt an intercultural approach in health and social protection systems, and create or strengthen mechanisms for participation in decision-making so that policies and programs respond adequately to the needs of these populations[10].

Likewise, important gaps are recorded in other health indicators – for example, life expectancy, indicators of infant nutrition, suicide, maternal health, among others[11]. Furthermore, some notable disparities are found in the access to essential water and sanitation services, which are crucial to health and nutrition[3], as well as affiliation to health systems by socioeconomic status. Disparities associated with the multiple dimensions of the social inequality matrix are evident in all these indicators.

While affiliation to health systems has been on the rise since the early 2000s with declining socioeconomic gaps, there is still a long way to go to reach more equitable levels of access[1]. As shown in Graph 2, despite a significant increase in coverage, especially in the first income deciles, which reduced inequalities between deciles, a difference of 37 percentage points remains between the lowest and highest income deciles . Moreover, affiliation to a health system does not guarantee effective access (which can be restricted by economic barriers, such as co-payments), or the quality of services received.

These challenges demand the implementation of intersectoral strategies and interventions that holistically address health inequalities from a rights perspective. In particular, it is imperative to have strengthened health systems that are integrated with universal social protection systems that are sensitive to differences, that tackle the social determinants of health – such as poverty or exclusion – throughout the cycle of life.

Social protection policies to address health inequalities: reflection and evidence

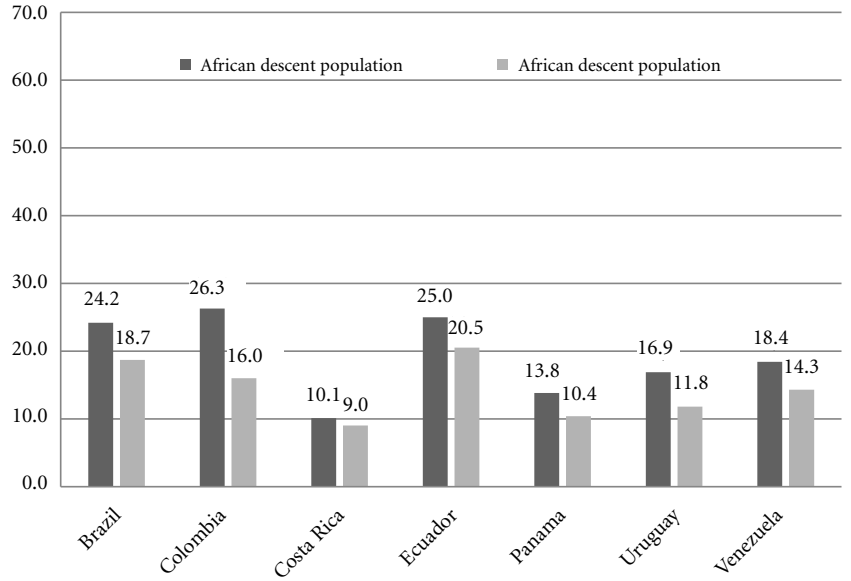
According to the High-Level Commission Report "Universal Health in the 21st Century: 40 years of Alma-Ata"[10], on which most of this section is based, there is a growing recognition of the role of social protection in the eradication of poverty, the reduction of vulnerability and inequality, and the promotion of inclusive development, which have positive impacts on the health of the population.

Social protection focuses on three main elements: essential well-being guarantees, assurance against risks arising from the context or life cycle, and moderation or reparation of social damages arising from social problems or risks. Following this concept, social protection is aimed at responding not only to the risks faced by the entire population (for example, disability or old age) but also to structural problems, such as poverty and inequality[12]. Likewise, social protection should be understood from a broad and comprehensive vision, which includes both non-contributory and contributory policies and programs, taking into account labor market regulation measures and care systems[13].

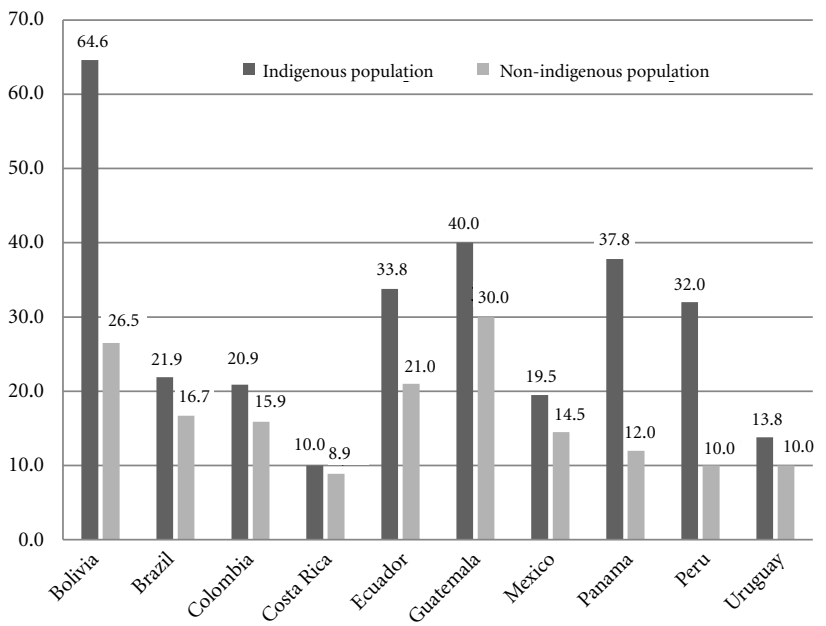
The various social protection mechanisms directly reduce the high costs associated with go-

Ciência & Saúde Coletiva, 25(5):1587-1598, 2020

A. African descent and non-African descent

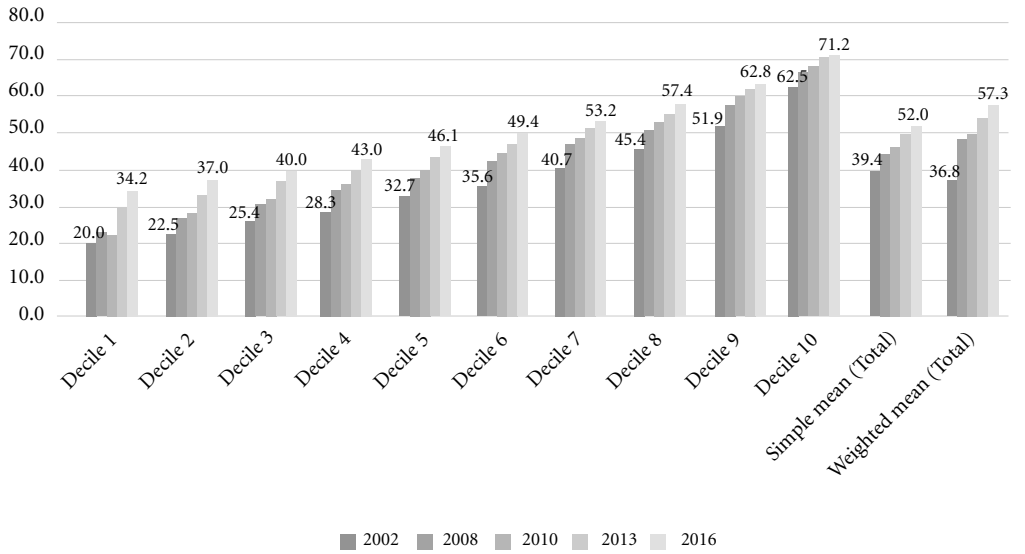


B. Indigenous and non-indigenous population



Graph 1. Latin America: infant mortality in children under 1 year of age by race and ethnicity around 2010. (Number of deaths per 1,000 live births).

Source: A: ECLAC (2017), Situación de las personas afrodescendientes en América Latina y desafíos de políticas para la garantía de sus derechos (9) y B: ECLAC (2017), Linkages between the social and production spheres: Gaps, pillars and challenges[8].



Graph 2. Latin America (14 countries): affiliation or contribution to health systems for employed persons aged 15 years and over, by income deciles, national totals, 2002-2016 /a /b. (In percentages).

Source: ECLAC, 2019 Social Panorama of Latin America 2018[1].

a/ In Argentina, it corresponds to employees aged 15 years and over. The information for Mexico in 2016 is not strictly comparable with that of previous years due to changes in the wording of some of the questions regarding access to social security. See more details of these changes, their effects on the estimation of social security coverage (health and pensions) and procedures to adjust this estimate in CONEVAL (2017). b/ Simple mean of Argentina (urban areas), Bolivia (Plurinational State of), Chile, Colombia, Costa Rica, Ecuador, El Salvador, Guatemala, Honduras, Mexico, Nicaragua, Paraguay, Peru, and Uruguay (urban areas).

ing to health services and mitigate the impact of other indirect costs (such as loss of income due to illness, disability or unemployment, non-medical expenses associated with using health services, such as transport, food, and care). In this way, social protection can prevent households from falling into poverty or worsening their poverty situation. On the other hand, it can support in overcoming of access barriers experienced by specific populations, such as African-descent people, indigenous people, those residing in rural areas, among others. Below are some examples of the interconnection between social protection mechanisms and the reduction of health inequalities.

Social protection in childhood

From a prevention perspective, the first stages of the life cycle are critical: during these stages, the foundations are laid for the future cognitive, affective, and social development of people. Therefore, intervening during these stages can contribute to the reduction of long-term health inequalities and interrupt the intergenerational transmission of poverty and inequality.

Proper, healthy nutrition from an early age and the adoption of good eating habits can help prevent health problems in the later stages of the life cycle. Several social protection strategies exist relating to nutrition aimed primarily at pregnant and lactating women, preschool-aged children, as well as primary- and secondary-school students. These include supplementary and school food programs, breastfeeding promotion, food distribution, and micronutrient supplementation and fortification programs. Some outstanding programs are the Social Milk Supply Program of Mexico, the National School Food Program of Brazil, and the *Qali Warma* National School Food Program of Peru.

Ciência & Saúde Coletiva, 25(5):1587-1598, 2020

Additionally, comprehensive care policies and comprehensive early childhood protection systems attempt to articulate the set of actions, policies, plans, and programs that are executed by different State authorities together with other actors, in particular civil society, to ensure that all children enjoy their rights without discrimination, while special situations are specifically addressed[8]. These policies seek to monitor children in their development process through the different stages that comprise early childhood, thus combining interventions in health, nutrition, and early education and care. Since these policies are aimed at protecting and promoting the rights of all children, they also promote a vision of social policy aimed at early childhood as something that involves society as a whole and not something merely intended for children in situations of poverty and extreme poverty. From a multidimensional approach and with integrated paths of action, these policies can create a chain of opportunities and favor the development of capacities throughout the life cycle, thus reducing inequalities[8]. Some examples of these policies are *Brasil Carinhoso*, *Chile Crece Contigo*, *Uruguay Crece Contigo*, *De Cero a Siempre* (Colombia) and *Educa a tu Hijo* (Cuba). Other countries that have made substantial progress in early childhood strategies are Ecuador, Panama, Peru, and the Dominican Republic.

Conditional cash transfer programs

In the last two decades, most Latin American countries have implemented conditional cash transfer programs (CCTs) that are intended for families living in poverty and extreme poverty. These non-contributory social protection instruments have had positive effects on various health and nutrition indicators. The region currently has 30 CCTs in 20 countries, reaching 133.5 million people in 2017 with an expenditure equivalent to 0.37% of regional GDP. Despite sharing common characteristics, the programs differ in their components, coverage, amounts transferred, role, and application of conditionalities[13-15].

CCTs operate through two parallel channels – on the one hand, they seek to increase the resources low-income households have for consumption, in order to meet their basic needs. On the other, they promote the human development of its members to interrupt the intergenerational transmission of poverty. Moreover, access to a range of social services is facilitated, provided that participating families adhere to specific commitments in the areas of education, health, and nutrition.

The inclusion of health conditionalities and complementary health interventions in the CCTs (Chart 2) has served to stimulate the demand for health services, often in remote rural or marginal urban areas, where their supply is scarce or of inferior quality. Therefore, these programs have had a positive effect, facilitating the access of traditionally excluded population groups to health services. CCTs promote equity, focusing on identifying and addressing the specific needs of people in poverty. Furthermore, they can boost universal health coverage, adapting services to the needs of excluded people, and introducing an equitable approach to universal programs[16].

CCTs have undergone several evaluations[15]. The evidence regarding the results of these programs shows increased access to health services among children and adolescents of participating families. Positive results have also been recorded in various health indicators and nutritional status[17], although the evaluations indicate some heterogeneity of these positive effects, depending, for example, on the area of residence, gender, age, and duration of participation in the program[16]. Of course, improvements in health and nutrition outcomes associated with these programs depend on the existence of services in sufficient quality and quantity[16]. At the macro level, a positive effect has been the higher demand for health services, which has stimulated the expansion of the supply of these services and a greater proximity of the State and a range of sectoral policies and social promotion programs to excluded populations, thus reducing access barriers and health inequalities.

Health universalization

While the debate on the universalization of health in the region has progressed and gained ground on its essential aspects, conceptual, practical, and operational challenges on how to achieve it[18] remain. Different health system reforms in Latin America, sustained by a higher public health spending by the central government, which increased from 1.4% of GDP in 2000 to 2.2% in 2016[1], have allowed expanded coverage and equity in access during the last fifteen years. Although these figures do not cover all public health social spending, they are still very far from what is recommended by the Pan American Health Organization (6% of GDP). Moreover, the characteristics of health systems in terms

Chart 2. Health conditionalities in conditional cash transfer programs in Latin America, 2018[a].

Country	Program	Medical checkups (children)	Medical checkups (pregnant women)	Medical checkups (older adults and people with disabilities)	Vaccines (children)	Vaccines (pregnant women)	Health counseling
Argentina	Universal Child Allowance for Social Protection	0-18 years	X		0-18 years	X	X
Bolivia (Plurinational State of)	"Juana Azurduy" Mother-Child Grant	0-2 years	X		0-2 years	X	X
Brazil	*Bolsa Família* (Family Grant)	0-6 years	X		0-6 years		
Chile	Securities and Opportunities / Family Ethical Income	0-5 years					
Colombia	More Families in Action	0-5 years					X
Costa Rica	Avancemos (Moving Ahead)	12-25 years[b]					
Ecuador	Human Development Grant	0-5 years	X				X
El Salvador	Program of Support to Communities inr Solidarity in El Salvador	0-4 years	X		0-4 years		
Guatemala	Social Allowance	0-5 years	X				
Honduras	Better Life Bonus	0-5 years	X				
Mexico	Prospera (Thrive)	0-19 years	X	X			X
Panama	Red de Oportunidades (Network of Opportunities)	0-4 years	X		0-4 years		
Paraguay	*Tepokorâ*	0-18 years	X	X	0-18 years		X
Peru	Juntos (Together)	0-5 years	X				
Dominican Republic	Progresando con Solidaridad (Progressing with Solidarity)	0-4 years	X				X
Uruguay	Family Allowances / Equity Plan	0-18 years		X			
Latin America	Number of programs with health conditionality	16	11	3	6	2	7

Source: Own elaboration, based on Cecchini and Vera Soares16, Conditional cash transfers and health in Latin America. Lancet, 385 (9975): e32 – e34 and ECLAC, Database of non-contributory social protection programs in Latin America and the Caribbean [online] https://dds.cepal.org/bpsnc.

a X in a cell indicates that the indicated category is part of the CCT conditionality, and an empty cell indicates that the category is not part of the program conditionalities. b The Costa Rican Social Security Fund (CCSS) conducts a complete medical evaluation of students enrolled in public high schools during the school year.

Ciência & Saúde Coletiva, 25(5):1587-1598, 2020

of investment, out-of-pocket costs, coverage, results, and integration between public health and social security systems are very different between countries. These differences are related to the historical trend of the welfare state, which in turn is influenced by economic, social, demographic, and political factors of each country.

In Latin America, Brazil (Unified Health System) and Cuba (National Health System) guarantee free universal health coverage, financed by general taxes, while Costa Rica has achieved universalization through social insurance, which from the 1980s began to include informal workers and low-income families[19]. However, universal coverage is not enough to ensure universal access, where all can make effective use of health services, without facing discrimination or barriers. Furthermore, from the perspective of equality, there is a concern that strong fragmentation and overlapping of benefits and coverage persist, which are evident in the significant disparities in the quality of services that are accessed by different population groups. Generally, health systems in Latin America are organized around public sector services for people in poverty, social security services for formal workers, and private services for those who can afford them[20]. In this way, these systems remain segregated and manifestly unequal by offering different services and different quality services to different population groups, so they are far from being genuinely universal and equitable systems.

Disparities in access and quality of health services are one of the clearest expressions of inequality in the region. It is necessary to strengthen countries' commitment to universal coverage and access to health in order to leave no one behind, a crucial step to guarantee the universal right to health, as well as to build universal social protection systems from a perspective of rights and advance in the fulfillment of the commitments enshrined in the 2030 Agenda for Sustainable Development. Progress must also be made to improve the quality of health services and promote a comprehensive and holistic approach to health in order to create positive synergistic relationships with other dimensions of well-being. There is ample evidence that articulated policies on education, labor market, local development, social protection and gender and ethnic-racial equality, among others, can contribute to improving the health status of the population.

Moreover, it is crucial to keep in mind that, even in countries where the law guarantees universal coverage, effective access to health services may be limited by economic, geographical, cultural, linguistic, accessibility, and attitudinal barriers, among others. In light of this situation, and the multiple inequalities that characterize Latin American societies, universal policies that are sensitive to differences must be adopted. These policies are based on a rights approach with a universal scope, which apply complementary focused mechanisms or affirmative action to overcome access barriers to health services faced by different population groups[3,5,8].

Social protection and Primary Health Care: complementary strategies that strengthen each other to move towards the full enjoyment of rights

Primary Health Care (PHC) is a strategy focused on people and communities that seeks the effective exercise of the right to health through access to integrated, quality, and affordable essential health services. A little more than 40 years since the Declaration of Alma-Ata that strongly installed PHC on the global health agenda, challenges remain, which has led to a call to renew and strengthen efforts around PHC[10].

Besides their central role in reducing health inequalities, social protection instruments can strengthen PHC to guarantee the right to health. As stated in the Declaration of Alma-Ata, within the framework of health systems, the PHC performs functions that transcend the first level of contact of individuals, family, and community with the national health system and include the provision of promotion, prevention, treatment and rehabilitation services. In turn, social protection instruments can act on various fronts to strengthen PHC and help guarantee all people a level of health that allows them to lead social, economically productive lives, as established in the Declaration of Alma-Ata. Through the expanded coverage and universal access, health and nutrition promotion, and prevention actions, the strengthening of policy coherence and, most fundamentally, the fight against poverty, inequality, and exclusion, social protection plays an indispensable role for the advancement in guaranteeing the right to health in the region and overcoming inequalities in this area.

Thus, social protection and PHC must be conceived as complementary strategies that mutually reinforce each other to advance towards the full enjoyment of rights, including health (Chart 3). For example, insofar as social protection mechanisms are aimed at reducing the risks

Chart 3. Examples of social protection mechanisms that can strengthen PHC.

Componente de la protección social	Intervenciones de protección social y su vínculo con elementos de la APS
Non-contributory pillar	**Conditional cash transfers:** . To expand access to health services, particularly those related to maternal and child health, to populations in situations of poverty and extreme poverty . To transmit health information for promotion and prevention to participating families . To promote intersectoral coordination **In-kind transfers (e.g., food or nutritional supplementation programs):** *Address the nutritional needs of children, especially those living in poverty and extreme poverty. Comprehensive early childhood care programs:* .To articulate actions in health, nutrition, education, and early childhood care to promote full development . To promote intersectoral coordination *Promotion and access to housing programs:* . To expand access to housing with essential services and reduce exposure to environmental health risks
Contributory pillar	**Health insurance:** . To expand coverage and access to health services . To provide financial protection to households **Maternity/paternity and parental leaves and protection against dismissal during pregnancy and the postpartum period:** . To protect the physical and mental health of female workers during pregnancy; to facilitate mother/father bonding and breastfeeding

Source: Own elaboration.

faced by children, seeking to ensure adequate nutrition and access to quality health and education services, they can promote healthy, cognitive, affective and social development of children, with positive effects for their health and the reduction of inequalities in health and other areas, during this and subsequent stages of the life cycle.

Moreover, conditional transfer programs seek to expand the access of participating families to local health services, as well as promote adequate nutrition and provide information and advice on health issues. Finally, various reforms have been carried out in the countries of the region to expand the coverage and quality of the benefits of social protection instruments that contribute to promoting universal health and reducing inequalities[21]. An example of this is the Plan AUGE in Chile, under which the Explicit Health Guarantees (GES) were created, which ensure certain benefits related to the prevention, treatment, and rehabilitation of diseases included in an essential list (among them, HIV/AIDS and different types of cancer)[22].

Conclusions

The 2030 Agenda for Sustainable Development expresses a consensus on the need to advance towards more inclusive, supportive, and cohesive societies. At the same time, it sets people at the center, promoting a model of sustainable development and calling for "leaving no one behind" on the path of development and to attend those furthest left behind first[3]. Therefore, the 2030 Agenda is focused on the reduction of inequality between and within countries, understood from a multidimensional and comprehensive approach.

Fighting inequality in all its expressions is an ethical imperative. However, in a region marked by deep structural gaps that are expressed in various fields, including health, it is also a necessary condition for sustainable development. Social inequalities are not only a key obstacle to the effective enjoyment of economic, social, and cultural rights. They also harm productivity, taxation, environmental sustainability, and the higher or lower penetration of the knowledge society[5].

Ciência & Saúde Coletiva, 25(5):1587-1598, 2020

The fulfillment of the 2030 Agenda faces enormous challenges, with growing inequality worldwide (related to increasing levels of the concentration of wealth), geopolitical and economic uncertainty, and a development model that damages the environment. In Latin America, these challenges are of great magnitude, considering that there are 184 million people living in poverty (of which 62 million are in extreme poverty)[1], in addition to a significant percentage of the population being vulnerable to poverty. This is not only represents a violation to the fundamental rights of minimum levels of well-being (including the right to health) and social protection, it also translates into important limits to the development of the full productive and citizen potential of these people. It is a harsh reality that undermines the possibilities of sustainable development in our region.

The deep inequalities in people's health status cannot be naturalized as yet another dimension of the culture of privilege. The sharp contrast between the quality of care in the public and private systems, and the dramatic disparities in health indicators such as infant mortality, unplanned teenage pregnancy, and life expectancy, among others, are evidence of the persistence of privileges in society and different discrimination mechanisms[5]. Access to health can reduce gaps, as long as they are quality services, so concrete actions are required to improve the quality of health services and guarantee access to those services for the entire population.

On the other hand, it is essential to remember that the remarkable advances in access and health outcomes of the last decades occurred in a favorable economic context where policies oriented to the reduction of poverty and inequality, the expansion and strengthening of social protection systems and active policies in the labor market. Although the current economic context is less auspicious, or precisely because of that, such policies must be more present than ever to safeguard the achievements and avoid setbacks[23].

This situation demands integrated policy responses that can create synergies between different sectors, making efficient use of the limited resources available, in pursuit of common objectives. Keeping a broad and integrated view of health and social protection, taking into account the social inequality matrix and the social determinants of health framework is crucial to leaving no one behind on the path of development in Latin America. The reduction of health inequalities must be a priority for all the countries of the continent, regardless of their income and development levels. A way forward in that direction is to promote the construction and strengthening of universal and integrated social protection systems throughout the life cycle for the health of the population and the reduction of health inequalities.

Collaborations

L Abramo, S Cecchini, and H Ullmann contributed to the elaboration, research, and drafting of this text.

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