Already a key component of sustainable development policies, the alleviation of inequalities within and between countries also stands as a policy goal, and deserves to take centre stage of the Sustainable Development Goals, agreed during the Rio+20 Summit in 2012. The 2013 edition of A Planet for Life represents a unique international initiative grounded on conceptual and strategic thinking, and – most importantly – empirical experiments, conducted on five continents and touching on multiple realities. This unprecedented collection of works proposes a solid empirical approach, rather than an ideological one, to inform future debate.

The case studies collected in this volume demonstrate the complexity of the new systems required to accommodate each country’s specific economic, political and cultural realities. These systems combine technical, financial, legal, fiscal and organizational elements with a great deal of applied expertise, and must be articulated within a clear, well-understood, growth- and job-generating development strategy.

Inequality reduction does not occur by decree; neither does it automatically arise through economic growth, nor through policies that equalize incomes downward via blind taxing and spending. Inequality reduction involves a collaborative effort that must motivate all concerned parties, one that constitutes a genuine political and social innovation, and one that often runs counter to prevailing political and economic forces.
In their book, The Sprit Level: Why More Equal Societies Almost Always Do Better, Richard Wilkinson and Kate Pickett develop a thesis – “equality is healthy” – that has been incorrectly interpreted. The authors do not argue that income and wealth inequality directly and entirely cause dysfunctional societies, nor do they call for an equalizing of incomes to achieve absolute equality. Ultimately, improvements in living conditions depend on the quality of programmes funded through taxation and redistribution policies.

**Income inequalities, health inequalities and social progress**

Different kinds of inequalities within low and middle-income countries as well as global or “North-South” inequalities have been recognizable for a long time. However, since the global economic crisis of 2008, inequality has resurfaced as a major public and political concern within rich countries. This crisis brought to light the unprecedented scale of the personal incomes and wealth of bankers, corporate executives and the top one per cent of the population in countries such as the United States and the United Kingdom. Greater awareness of the absolute and relative levels of wealth also produced much discussion about the causal role of the pursuit of personal wealth, on a scale of millions and billions, in the near collapse of the global financial system. The resulting social demonstrations such as the “Occupy” movement, many post-2008 election campaigns and anti-austerity protests have focused on inequalities – in wealth, job prospects for the young, education costs, social security, old age security, and so forth. It could also be argued that the political revolutions across the Middle East were motivated by inequality. After all, the Arab Spring was catalysed by a Tunisian fruit seller who set himself on fire as a form of protest expressing frustration at his relative inequality of opportunity to achieve a minimally decent life.

The global economic crisis and other world events created an unusually receptive environment for the publication of Richard Wilkinson and Kate Pickett’s book, “The Sprit Level: Why More Equal Societies Almost Always Do Better” (hereafter “TSL”) in 2009. The book has been fantastically popular in many countries because it purports to provide scientific evidence about how inequality is bad for societies as
Reducing inequalities

A PLANET FOR LIFE

well as what to do about it. TSL’s greatest appeal is perhaps that it is understood to argue specifically for the case that income and wealth inequality is bad for societies and, therefore, aggressive redistribution of income and wealth is, or will be, good for societies. The authors have given speeches around the world to a wide range of audiences, often managing to reach inaccessible and influential policy makers. The wide interest in their book is partly due to the context of great uncertainty and debate about what constitutes good social and economic systems. The authors seem to provide academic and scientific arguments that are more coherent, evidence-based and legitimate than the demands from the protestors in the streets or the opinions of media pundits.

A careful reading of the book, however, as well as an appreciation of the body of scientific literature that TSL draws from, shows that neither one of the two popular take-away messages is accurate. The authors do not argue that income and wealth inequalities directly and wholly cause dysfunctional societies or cause the lives of people to go badly. Nor do they advocate a simple wholesale redistribution of income and wealth, or an “equalizing down” of incomes to achieve absolute equality. So if these two take-away messages are not accurate reflections of TSL, then what exactly is their argument?

Income inequality and health

The central thesis of TSL is that in countries that are above the Gross National Income (GNI) threshold of $25,000 per person there is a positive relationship between income inequality and a wide variety of social problems. That is, above the $25,000 GNI per capita threshold, the more income inequality in a country, the greater amount of social problems including poor health, teenage births, homicides, imprisonment rates, low educational performance of children, and so forth (Wilkinson and Pickett, 2009: p. 19). This thesis challenges a variety of dominant views about the causes of “social bads” in a variety of domains, and most prominently it argues against the view that material poverty is the main cause of such problems. Wilkinson and Pickett show that average levels of income across countries, and across regions and states within countries, do not have a statistical relationship with the levels of social ills. They interpret this finding as meaning that in rich countries (i.e. above $25,000 GNI per capita) there has been a delinking between absolute material conditions and quality of life and that, in comparison, the level of income inequality has a positive statistical relationship with levels of social problems above this threshold.

The identification of this relationship has led many to conclude that inequality in incomes directly causes many social problems and therefore, reducing income inequalities, most immediately through income redistribution, is the necessary remedy. Such a conclusion may be understandable because a whole variety of ideologies and intuitions about equality support the idea of income equality or at least, support the reduction of gross inequalities between the rich and the poor. However, this interpretation or policy prescription does not accurately reflect the conclusions presented in TSL. While the authors highlight that countries that do better regarding
Reducing Inequalities

Various health achievements and social bads have redistributive tax systems and large state welfare programmes, they also suggest that there are many different ways to achieve such outcomes (Wilkinson and Pickett, 2009: Ch. 16). To understand why the equalization of incomes or the limitation of income inequalities prior to taxation is only one possible avenue to improving social progress requires a deeper look into the research. Wilkinson and Pickett argue that income inequality shows how hierarchical a society is; income inequalities show the social distances between people and the functioning of social stratification (Wilkinson and Pickett, 2009: p. 27). Income inequalities reflect social inequalities, and they both reinforce each other.

Furthermore, evidence is also presented that seems to show that the steeper the social gradient of a particular social problem – i.e. the more skewed the distribution of a problem is towards the bottom of the socio-economic hierarchy – the stronger the relationship with income inequality. Moreover, the authors argue that a relationship between income inequality and social bads exists, or only becomes visible, when comparing groups that have meaningful social differences; income inequality would not appear as a contributing factor to problems among families.

The work of Wilkinson and Pickett shows that the degree of inequality in a society is strongly correlated with the level of social problems experienced by that society. The most egalitarian societies (Japan, Sweden, Finland, Denmark) are also those with the lowest levels of certain problems, including obesity, incarceration rates, numbers of teenage mothers and people with low mathematical ability.
within a deprived neighbourhood, but would appear when comparing neighbourhoods of different levels of wealth. Something about the social differences between groups of people, most easily represented by income differences, seems to play an important part in the levels of social ills experienced by those at the bottom as well as the higher levels experienced throughout the entire population. But what are these social differences if not directly income inequality, and how do they shape the pathways to various social problems?

**Social Epidemiology**

Research on social gradients (i.e. inequalities across the socio-economic hierarchy) and influence of social factors on human deprivations, particularly health related issues, have been a central focus of the relatively new discipline of social epidemiology. It is often contrasted with “classic” or “biomedical” epidemiology in which the scope of research on the causes of disease is limited to individual-level factors that include individual biology, individual behaviours, and individual-level exposures to harmful organisms and physical particles. These three categories of factors are often metaphorically described as making up a multi-factoral “causal pie” or forming the links in a “web of causation” (Krieger, 2000; Rothman et al., 2008).

Despite its dominance for most of the 20th century, this individual-level biomedical model of disease has been increasingly challenged over the past four decades because of its persistent limitations in fully identifying the causes of many chronic and degenerative diseases, as well as its inability to explain the dynamics and distribution patterns of population-level health (Syme, 1996; Krieger, 1994; Krieger, 2001; Susser and Susser, 1996a; Susser and Susser, 1996b; Schwartz et al., 1999; Susser, 1999). Molecular epidemiology, which delves even deeper into the individual, has been promoted as a panacea to the classic model's explanatory limitations. In contrast, social epidemiology, which focuses on supra-individual factors, and the basic tenets of its research, has received considerably less public attention – despite its insights and productivity (Marmot and Wilkinson, 1999; Berkman and Kawachi, 2000; Marmot et al., 1997). The lack of greater public awareness of social epidemiological research may or may not be surprising, depending on one's worldview, as social epidemiology brings to light two very politically charged issues: that of the social causation of preventable illness and mortality, and the unequal social distribution of illness and mortality. Unlike classic or molecular epidemiology, social epidemiology puts social conditions, policies and choices squarely in the causal explanations of preventable illness and mortality and their social patterning.

Moving away from the classic biomedical model that was very productive and dominant in the late twentieth century, social epidemiologists are expanding the causal chain outward from the proximate individual-level factors to include the causes of the proximate causes, and identifying their discrete and cumulative effects throughout the life cycle, starting from the womb. Social epidemiology also expands the causal chain upwards to incorporate multiple levels of factors – such as the
Reducing inequalities

Chapter 6

A PLANET FOR LIFE

The focus on social factors affecting health is not fundamentally new. There is a long history of research into the identification of the role of the social environment...
in community and social medicine, while Louis-René Villermé and Rudolph Virchow conducted epidemiological work in this field in the 19th century. However, modern social epidemiology harnesses the most current epidemiological tools and methodologies combined with sociological analysis to explicitly identify supra-individual social phenomena that affect both the causation and distribution of ill-health across individuals and social groups, within and across countries (Berkman and Kawachi, 2000; Marmot and Wilkinson, 1999).

In light of the productivity and profound insights of social epidemiology, the late J. W. Lee, then Director-General of the World Health Organization, set up the WHO Commission on Social Determinants of Health (“the Commission”) in 2005. Its mission was to collect and synthesize global evidence on the social determinants of health, assess their impact on health inequity, and make recommendations for action to address that inequity. Members of the Commission and its secretariat were motivated by three driving forces: a belief in social justice, respect for evidence, and frustration that there was far too little action on the social determinants of ill health and health inequalities. These powerfully motivating forces led to three years of detailed work compiling and analysing research, consultations with experts from around the world as well as across many disciplines and professions, meetings with governments and practitioners, and the production of a final report and recommendations. Rather than being an end in itself, the work of the Commission and the resultant report, Closing the gap in a generation: Health equity through action on the social determinants of health was intended to instigate discussions within institutions and the public sphere, and help promote social action and policies to advance health and health equity, both within countries and transnationally.

In the first truly global application of social epidemiology, the Commission articulated the causal nested framework in the following way:

1. The conditions of daily life in which individuals are born, grow, live, work and age determine their experience of morbidity and length of life span.

2. These daily living conditions produce proximal determinants, such as exposure to harmful substances and biological risks; availability of material needs, such as food, potable water, shelter and health care; as well as social environments that affect psychobiological pathways and health-related behaviours.

3. These daily conditions in turn have structural drivers or “causes of causes” – the economic, social and political conditions that, together with background social


2. This frustration is associated with two main areas. First, that the concern for addressing preventable ill-health and mortality has to go beyond healthcare to also include the causes, particularly the social conditions. Most global and national health policies often focus only on healthcare. The second source of frustration was that despite decades of epidemiological research findings on the social causes of ill-health and mortality, health policy makers were not making use of the findings.
and cultural norms, create and distribute the proximate causes across individuals and social groups.

The starting point of social epidemiology is that individual-level factors do not provide sufficient causal explanations for the significant health differences between groups of human beings defined by such social characteristics as nationality, education, income, occupation, gender, race/ethnicity or geographical residence. The hypothesis is that factors created by the social environment have a significant influence in the causal pathways to illness in individuals and unequally distribute ill-health across social groups. Under this general hypothesis, there are a number of different pathways or explanations that are currently being researched (Bambra, 2011; Mackenbach, 2012). Following this line of reasoning, the Commission started from the premise that there is no purely biological causal explanation for the marked differences in life expectancies across countries; for example, the gross inequality in life-expectancy between the Japanese (83 years) and Malawians (48 years) cannot be explained by differences in the biological endowments of the Japanese compared to Malawian populations. Rather, the Commission argued that differences in life expectancies and health profiles are determined by social environments – by economic, political, and social policies and processes driven by social and cultural values that create and distribute the daily living conditions of people in different locations around the world.

Importantly, social epidemiological research not only explodes outward the classic model of epidemiology from the individual unit of analysis, but the research also militates against the various social consequences of applying the biomedical model. Some of these social consequences include the narrow focus on health care provision and behavioural change as the primary avenues to improving health; being inattentive to social group inequalities in health; exaggerating individual volition and responsibility in health outcomes; and focusing on the material poverty of the most disadvantaged while ignoring psychosocial environments that produce preventable ill health in the entire population. Such drawbacks of a narrowly individual-level analysis are not only a concern for domestic health policies, but also for global health policies. These can include, inter alia, development assistance for health programmes, transnational health policies, or domestic health policies addressing extraterritorial health threats.

The Wilkinson Thesis
It is this context of expanding the scope of epidemiology and identifying the social determinants of ill health and premature mortality as well as their distribution that has produced the TSL. Starting in the early 1990s Richard Wilkinson began publishing research findings showing that greater income inequality in societies correlated with a lower average population health and higher social inequalities in health (Wilkinson, 1992). The “Wilkinson thesis” which was narrower in scope than that presented in TSL, asserted that in countries above a $25,000 GNP per capita threshold, larger average income differences between classes are associated with a
steeper gradient in health achievements and higher, overall premature mortality in the entire population (Kawachi et al., 1999; Wilkinson, 1997; Wilkinson, 2000). Below the threshold, income inequality shows no correlation with the gradient or distribution in health outcomes.

Across a number of industrialized countries, and within regions of countries, Wilkinson shows that the steepness of the health gradient is indeed associated with level of income inequality. In TSL Wilkinson and Pickett show that income inequality is linked with a wide range of social problems aside from disparities in health achievements (Wilkinson and Pickett, 2009). While many have understood this research as referring to material determinants of health, Wilkinson argues that the effect of income inequality lies first in the psychosocial effects of being of lower social status, experiencing subordination, or being denied respect (Wilkinson, 1996). Entrenched and increasing income inequality affects social standing and in turn, leads to particular biological processes in the individual, such as chronic anxiety, permanent increases in stress hormones such as cortisol, more atherosclerosis and poorer immunity. The total result of these processes that occur through psychobiological pathways is said to be analogous to rapid ageing (Kawachi et al., 1999, p 493). In TSL, Wilkinson & Pickett further argue that an environment of gross inequality undermines trust between people and community life, including increased violence. It also increases status competition and consumerism. And, by affecting early life, it affects people’s abilities to build relationships, empathize, and their aggressiveness (Wilkinson and Pickett, 2009: p. 231).

The Wilkinson thesis, development and health inequalities

A quick review of the literature on social epidemiology soon reveals that most research on the social determinants of health and social inequalities in health achievements has so far been done mostly in developed economies. Social epidemiology begins with an interest in the persistence of ill health and the unequal distribution of preventable ill health and mortality despite the availability of healthcare and social programmes to meet basic needs. In contrast, health research in developing countries has largely been focused on the causes of infectious diseases and controlling fertility, and less focused on the social inequalities in health achievements. The lack of research on social determinants in developing countries appears to support the economist Angus Deaton’s argument that for centuries the better-off have often benefited from new health technologies first (Deaton, 2011). That is, rich people and rich countries are often the first beneficiaries of state-of-the-art technologies, including research.

However, the Commission argued that social determinants of health and health inequalities affect all countries (World Health Organization and Commission on Social Determinants of Health, 2008). The final report showed how social gradients are visible in rich as well as poor countries. But efforts to apply social epidemiology and to globalize concern for the social determinants of health appear
Reducing inequalities

Chapter 6

Child well-being is an indicator of societal equity

Child well-being goes beyond the physical health of children. Equitable societies offer a better development framework for their younger members, with interesting exceptions such as Japan, which despite having a very equal distribution of income does not rank highly for child well-being.

to be weakened by research coming from within social epidemiology. In particular, by Wilkinson's thesis that it is only above the threshold level of $25,000 GNI per capita that the levels and gradient in mortality correlate with income inequality. This threshold, he writes, "represents a transition from the primacy of material constraints to social constraints as the limiting condition on the quality of human life" (Kawachi et al., 1999: p 27).

However, while his main finding is about what is happening above the threshold, Wilkinson may be far too quick in his conclusions about what is happening below it, and in making a peculiar distinction between material and social constraints. Under this threshold, it is far from certain that the determinants and distribution of premature mortality and impairments in societies can be adequately explained as being due largely to material constraints, including a lack of commodities such as healthcare. There may be a danger here of making the common mistake of confusing the cure with addressing the cause. For example, the poor reproductive health of girls and women, including deplorable rates of maternal mortality which are largely preventable, or the spread of HIV/AIDS are caused by social and cultural practices as much as they are by material deprivations, if not more so. To conclude
that poor health and premature mortality below the threshold is caused primarily by material constraints, based on a finding about income inequality above $25,000 GNI per capita, seems to simply represent the reassertion of a theory as being applicable to poor countries, when this theory is being forcefully rejected as having any relevance to rich countries. Just as the relationship between material conditions and ill health and quality of life is not straightforward in rich countries, nor is it the case in poor countries.

It would be even a greater error to conclude from Wilkinson’s thesis – given its identification of a threshold level or turning point of $25,000 GNI per capita – that economic development in the form of rising GNI per capita up to the threshold automatically brings with it improvements in life expectancy and lower prevalence of impairments. The argument that material conditions and health achievements are delinked above the GNI threshold may lead some to the conclusion that below the threshold, rising GNI automatically improves these material conditions and consequently improves health and quality of life. There is a widely held view, particularly among economists, that economic growth inevitably leads to dramatic improvements in life expectancy and infant mortality, while decreasing the overall burden of impairments and improving social prosperity (Bloom and Canning, 2007; Pritchett and Summers, 1996). This theory, which is often attributed to Samuel Preston (Preston, 1975; Preston, 2007), underlies a popular theory of epidemiological transition describing the movement of societies from an initial “under-developed” stage with a high burden of infectious diseases, to an “industrialised” stage with a high burden of chronic diseases (Omran, 1971). However, Simon Szreter and others argue that there is little historical evidence of an automatic link between economic growth and the improvement of health or welfare of individuals (Szreter, 1997; Biggs et al., 2010b; Sen, 1981).

In fact, Szreter, a public health historian, argues that industrialization released very disruptive forces into British society that were managed by the politics of public-health advocates and institutions. That is, social action had an influential role in the management of the process and the consequences of industrialization which do not appear to be captured by Preston’s and Omran’s theories. Amartya Sen also points to the modern-day importance of public discussion and agitation in the domain of health policy in such places as Thailand, India and China (Sen, 2011). In parallel discussions in economics, Sudhir Anand and Martin Ravallion show that indeed growth in GNP per capita is correlated with increasing life expectancy. But those improvements in life expectancies are largely explained by poverty alleviation programmes and spending on public health goods and services (Sen, 1999; Anand and Ravallion, 1993). In fact, after accounting for these two factors, there is not much left of the link between improvements in average incomes and life expectancy. So, a rise in GNP improves health only when resources are marshalled towards public health goods and services. Sen and Jean Drèze show a similar situation in India (Drèze and Sen, 2002). More recently, Biggs and colleagues have looked at 22 Latin American countries and shown that the relationship between GDP per capita and
health is mediated by poverty levels and income inequality (Biggs et al., 2010a).

It is worth expounding on the relationship between economic development and health because it is social factors that determine health and longevity, both above and below Wilkinson’s GNI per capita threshold. Wilkinson’s distinction between social versus material “constraints” on either side of the threshold seems based on the role of psychological factors related to relative social status and their influence on the onset of disease, factors that become prominent above the threshold. He contrasts these psychosocial pathways with material conditions affecting the health of individuals below the threshold. But why should psychosocial factors be considered as the only social factors affecting health? Given the wide variety of social factors that are currently the focus of social epidemiological research, it is surprising that the proximate cause model of disease and health impairment is being reasserted in poor countries. Much of the above-cited research (by Szreter, Anand, Ravillion, Biggs, Sen and others) has shown that economic growth on its own does not automatically improve health and longevity and, in particular, it does not ensure equitable achievements across populations. These improve because economic growth is usually accompanied by various social policies and provisions, such as poverty alleviation and investment in medical and public health programmes, as well as education. Economic policies are themselves important social determinants. And, of course, there are the exemplary cases of Costa Rica, Cuba, Sri Lanka and the Indian state of Kerala which achieve better health outcomes than many developed economies, despite their low GNP per capita, because of the positive impact of their social choices on the proximate causes of health (Sen, 1999, pp. 46-47).

The identification of a threshold where psychosocial factors related to relative inequality influence ill-health (and other social problems) should not be understood to mean that social factors do not affect health below the threshold. Indeed, social factors underlie both the psychological pathways in richer countries and the material pathways in poorer countries. In both rich and poor countries, going back in the chain of causation of ill health or any kind of impairment will inevitably lead to a meaningful social factor. TSL has largely been of interest to audiences in rich countries because of the public interest in income inequalities. However, for a global audience, an emphasis on the threshold as the tipping point at which material factors give way to socio-psycho-biological factors risks perpetuating the idea that rising GNP or economic growth automatically, without additional social policies, leads to health improvements. The notion that economic growth without supplementary social strategies will achieve improvements in health and quality of life has been profoundly contested in mainstream economics, but such debate does not seem to have reached social epidemiologists, perhaps because they mainly work in developed country contexts with little exposure to development related literature.

The relative influence of different factors on health varies across rich and poor societies, and across individuals. Wilkinson showed that in the United States and United Kingdom, psychological pathways have a great affect on health. In other countries, such as those researched by development economists, health may be more
influenced by material pathways determined by levels of public spending on social goods and programmes. The important thing to recognize is that even the proximate material causes of ill health in developing countries have social determinants that can range from acts of commission as well as social neglect.

It is also worth noting that Wilkinson and Pickett identify a variety of interventions to increase social equality, including reducing gross income differences before tax, redistributive taxes and welfare programmes. In the study of social hierarchy phenomena, it is clear that acting on incomes is really only one possible means of reducing distances between social positions. Given that income inequality does not directly cause poor health – the fact that one person’s monthly wage is less than another’s does not directly induce disease in the former – the real focus is on what is happening in the lives of individuals in relation to other individuals and groups. Income intervention is only one way to help individuals to avoid disease and other social deprivations. Above and below the GNI threshold, the actual target is an individual’s *ability* to achieve various physical and mental functionings, including the ability to avoid illness and premature mortality.

In light of the expansive scope of social epidemiological research to supplement the biomedical model, as well as the need to integrate debates on health and development, there is a pressing need for a “unified theory” of health causation and distribution. Social epidemiologists are aware of the need for a better paradigm for epidemiology that captures both individual and macro-level factors. But as the above discussion highlights, even the best social epidemiology research has not yet integrated state-of-the-art research on health and sustainable development, and it requires a better grounding in the realities of rich and poor societies. In addition, micro and macro analyses remain confined to developed country contexts and various assumptions about developing countries are not being sufficiently explored. There is a need for a unified theory that is applicable to the entire human species to defensibly allocate responsibility for health causation and distribution among the four categories of nature/biology, social conditions, environmental conditions and individual behaviour/agency. While a number of candidate paradigms exist, Amartya Sen’s work on development as a form of increasing capabilities offers great potential as a basis for such a theory (Venkatapuram, 2011). Sen was a member of the WHO Commission and a significant influence on the Commission’s arguments.

**Conclusion**

Given the renewed focus on income inequality as a result of TSL, it seems relevant to draw attention to long-standing discussions on precisely this subject in economics and especially, development economics. For decades, Sen has argued for a single or unified approach to evaluating social progress or sustainable development for all countries whether they are rich, poor or middle income. A central idea in this approach is the need to shift social and analytical concern from income inequality to economic inequality (Sen, 1997). Reflecting a long established view held by many economists, Sen argues that the importance of income is instrumental and
circumstantially contingent rather than intrinsic and categorical (this conclusion is reaffirmed by Wilkinson’s research which highlights income’s effect on health and quality of life, rather than its intrinsic nature). Sen demonstrates the important insights that are revealed when the impact of other social and economic influences on the quality of life are examined, aside from incomes and their inequalities. While not wholly discarding concerns over income inequality, which does have important consequences, Sen argues for an approach that targets capabilities, or the freedoms that individuals have to be and do what they have reason to value.

Integrating this approach with the Wilkinson thesis would mean that our moral and practical target is not a narrow focus on income inequality but the unequal capabilities of people to achieve good health or live a good life. Indeed, Wilkinson has clearly found that there is something about the how unequal societies are which affects the inequalities in the capabilities of individuals in society to pursue flourishing lives. Inequality in this view is not only morally bad as it reflects inequalities in the abilities of people to pursue good lives. It is doubly bad because the higher the inequality, the less free the people are in the lower parts of the social hierarchy, and the less free is the entire population.

While income inequality is indicative of social inequality, and also a cause of it, there is a wide range of social factors that cause ill health and other social ills. The focus on income alone therefore constitutes an incomplete and possibly incorrect approach. Wilkinson and other social epidemiologists have brought to light the important social factors that negatively impact on the lives of individuals in rich countries, while other researchers, particularly development economists, have shown how social action and public policies, in addition to economic growth, impacts on health achievements in poor countries. The goal now is to establish an analysis framework that addresses the entire human species on a single plane, which the Commission is attempting to do with its framework on the causation and distribution of health across the world. The great insight of Wilkinson’s thesis is that social inequalities in different domains, one of which is income, have a profound influence on the overall levels and distribution of constraints on the quality of life of individuals, social groups and national populations. It would be a shame if this major insight was forgotten and replaced by a more familiar focus on income inequality.
REFERENCES


Already a key component of sustainable development policies, the alleviation of inequalities within and between countries also stands as a policy goal, and deserves to take centre stage of the Sustainable Development Goals, agreed during the Rio+20 Summit in 2012.

The 2013 edition of *A Planet for Life* represents a unique international initiative grounded on conceptual and strategic thinking, and—most importantly—empirical experiments, conducted on five continents and touching on multiple realities. This unprecedented collection of works proposes a solid empirical approach, rather than an ideological one, to inform future debate.

The case studies collected in this volume demonstrate the complexity of the new systems required to accommodate each country’s specific economic, political and cultural realities. These systems combine technical, financial, legal, fiscal and organizational elements with a great deal of applied expertise, and must be articulated within a clear, well-understood, growth- and job-generating development strategy.

Inequality reduction does not occur by decree; neither does it automatically arise through economic growth, nor through policies that equalize incomes downward via blind taxing and spending. Inequality reduction involves a collaborative effort that must motivate all concerned parties, one that constitutes a genuine political and social innovation, and one that often runs counter to prevailing political and economic forces.