

***Understanding Health Equity:  
Key Concepts, Debates, and Developments in Canada***

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**Abstract**

Health inequalities exist and persist due to the quality and distribution of the social determinants of health, i.e., the day to day circumstances people live in. These circumstances are determined by governing policies and practices which are influenced by the State's political ideology and its socio-economic structures. Using a political economy approach, this paper takes a critical review of the literature on health equity in the Canadian context and clarifies key concepts pertaining to health equity and human rights. Findings of this review show that Canada has been performing poorly in addressing growing health inequalities, in part because of Canada's increasingly neo-liberal stance on public health over the last decade. This paper will argue that a human rights framework can offer a concrete tool for restructuring public policies and for taking action against these inequalities. By placing health equity on the policy agenda, Canada can help reduce social and income inequalities and optimize the health of its populations.

Keywords: health inequality, human rights, social justice, social determinants of health, public policy, health equity

International human rights treaties and documents highlight three areas that concern the right to equality and equity of individuals and groups: 1. *Equality of civil and political rights*. The most fundamental of these three rights, it implies freedom and elimination of all forms of discrimination. 2. *Equality of opportunities*. This requires creating supportive social, economic, cultural, and political conditions that enable all individuals to reach their full potential and fulfil their obligations as citizens. 3. *Equity in living conditions* for all individuals and households. This right refers to contextually determined “acceptable” ranges of inequalities in income, wealth, and other societal needs (United Nations [UN], 2006). The World Health Organization (2014) defines health equity as the absence of avoidable or remediable differences among groups of people represented by social, economic, demographic and geographic locations. Health inequity is an ethical and moral measure of inequalities in health and social conditions (income, education, housing, and food) as well as different forms of unjust discrimination that have negative health implications (United Nations, 2006).

Different public policy change models are used to examine how public policies are shaped. These models help to identify the approaches and actions required to address health inequalities. Public policy change models are distinguished by whether they are consensus models or conflict models of public policy change (Brooks & Miljan, 2003). Consensus models conceive the policy-making process as a rational and open process by which various interest groups compete by expressing their views and sharing their ideas to influence a more or less neutral State to implement desired public policy (Coburn, 2010). Conflict models of public policy-making consider the role of power and political ideology in shaping public policy decisions (Coburn, 2010). The pluralist public change model and political economy models

explain how public policy produces various forms of inequality (in the distribution of health and its determinants) as a result of competing political and economic forces between the State, the market, and civil society during the public policy process (Raphael, 2015). The pluralistic model is a consensus model and assumes all groups, regardless of their policy positions, will have their voices heard by government. The pluralist recognizes this often does not happen as those interest groups with financial and other resources available to them have the greatest influence in policy making (Howlett et al., 2009).

The political economy approach considers how political ideology and the relative power of the market versus the state shape public policy-making (Bryant, 2012; Coburn, 2010). It also explains how societal structures produce and distribute political, economic, and social resources, and how gender, social class, and race/ethnicity operate as social stratifications that create social and health inequalities (Armstrong, 2004). Accordingly, it points to the causes and consequences of inequalities in health. At the core of the political economy approach is the commitment to address social and health inequalities (Bryant, 2012). Implementing public policy (maintaining desired policy or creating desired policy) that supports health through action on the determinants of health is critical to reducing and eliminating health inequalities (Bryant, 2012).

Using a political economy approach, this paper takes a critical review of the literature on health equity in the Canadian context, clarifying the key concepts of health equity, social determinants of health, and human rights. By doing so, it reviews the discussions, debates and developments in the health equity arena. This paper argues that human rights and political economy approaches justify public policy action on tackling health inequalities. A political economy approach explains how public policy is created and implemented, and how its failure

leads to poor health and economic outcomes. The first section of the paper clarifies the concept of health equity, situating it in the human rights literature and social justice literature. The second section of the paper takes a historical perspective of developments in addressing inequalities in health in Canada and Western Europe. The third section looks at the social determinants of health in modern populations from a policy perspective. The last section discusses the ways in which Canada falls short in addressing the inequalities in health.

### **Concept of Health Equity, Human Rights and Social Justice**

‘Health inequities are systematic, socially produced and unfair’  
Margaret Whitehead & Goran Dahlgren (2006)

There is much confusion in the usage of the terms health inequality, health equity, and health disparity. These terms have important implications on policy and practice; it is therefore essential to remove any ambiguity in the definition of these terms (Braveman, 2014). The term “equity” is a vague and controversial notion, but it is also a value laden concept (United Nations [UN] 2006; Le Grand, 1987). It relates to fairness and justice and has moral and ethical connotations. The term “health inequity” relates to those differences in health which are avoidable, unnecessary, and unfair (Whitehead, 1991). Inequalities in health are measurable differences in health outcomes such as life expectancy, infant mortality, and quality of life. Health disparity refers to differences in health closely linked with social and economic disadvantage, specifically race, ethnicity, religion, gender, sexual orientation, or disability (Braveman, 2014). The dominant biomedical model in healthcare aims to equalize differences with respect to biological causes of disease. Health equity goes beyond biology and health behaviors—it strives to equalize differences in factors (socio-economic and psychological) that

support health. Inequities in health systematically put groups of people who are socially disadvantaged by virtue of gender, race, ethnicity, disability, and socioeconomic status at further disadvantage with respect to their health.

### ***Linking Human Rights, Social Justice and Health***

The concept of health equity is closely linked to the values and principles of human rights and social justice. A human rights and social justice perspective to health is critical in addressing growing health inequalities nationally and globally. Social justice upholds fair distribution of common advantages and sharing of common burdens (Rawls, 1971). The values and principles of social justice include fundamental rights, liberties, and opportunities for all members of the society without discrimination (Hankivsky, 1999). Applying the values and principles of social justice to health presumably leads to more democratic, just communities where people generally enjoy healthier lives (Hankivsky, 1999).

Human rights as laid out in the Universal Declaration of Human Rights (UDHR) are the inalienable fundamental legal rights to which every person is inherently entitled regardless of their race, ethnicity, religion, language, nationality, or status. The right to the highest attainable standard of health, and the right of equal opportunities to be healthy set forth in the World Health Organization (WHO) Constitution and the UDHR underpin the concept of health equity. The right to health framework ensures that states respect, protect, and fulfil the right to health. It commits them to promote equality and to confront the systemic and root-causes of inequality and discrimination through policies and programs (Office of the United Nations High Commissioner for Human Rights [OHCHR], 2015). Human rights are interdependent, indivisible, and

interrelated; that is, violation of the right to health may lead to deprivation of other human rights (OHCHR, 2008).

### ***The Right to Health***

The link between health, human rights, and the social determinants of health has been accepted by policy makers and researchers, yet at the institutional level the human rights agenda still remains marginal, contested, and under resourced (Hunt, 2008). A number of critical elements affect the full realization of the right to health: the fulfillment of certain State obligations related to the right to health are determined by available State resources and capacity; the right to health framework allows States to realize some rights progressively as sources become available; and in certain situations there is a deficit of enforcement of State obligations and a lack of scrutiny of the State's efficient use of resources in realizing the right to health (United Nations, General Assembly, 2014).

The International Human Rights Organization serves as a platform to advocate and enforce fairer distribution of resources within and between nations (National Pro Bono Resource Center, 2011); however, there is a lack of international mechanisms to hold transnational corporations liable for violations of human rights (United Nations, General Assembly, 2014). Inequities in health and social needs for individuals, groups, and populations continue because agents of power, wealth, and influence are unwilling to change the policies governing these inequalities or to allocate the resources to remedy the injustice. It is too frequently observed that the people in most need of claiming fundamental human rights are not in a position to make the claims or have the least capacity or ability to do so (National Pro Bono Resource Center, 2011).

### **Tackling Health Inequality: Historical Perspectives**

The observation that social and environmental factors significantly influence people's health had been observed for centuries, but it was not until the nineteenth century that health differences between the wealthy and the poor became politically inspired public debates. Nineteenth century public health activists Rudolf Virchow, Edwin Chadwick, and Friedrich Engels made important contributions to our knowledge of the social causation of illness and death. The past three decades have seen a succeeding generation of researchers rediscovering the link between societal conditions and illness and death.

#### ***Social Determinants in the Nineteenth Century***

Rudolf Virchow was a German physician and statesman, who was assigned the task of reporting on the Silesian typhus epidemic in 1848. It was one of the first health reports in history to link health problems to the social, economic, and cultural forces that governed the society, and to propose social reconstruction as a remedy to the health problems (Irwin & Scali, 2007). Edwin Chadwick, in his report on "The Sanitary Conditions of the Labouring Population" (1842), noted that poor health was directly related to the environment and lifestyle endured by the labouring poor. He argued that investing in public health ventures, such as clean water, sewerage, and adequate housing would not only improve the health of the poor but would also save money in the long run. Chadwick's recommendations spearheaded the enactment the British Public Health Act of 1848 which became the first step toward improved public health (Tulchinsky & Varavikova, 2014, p. 13). Friedrich Engels, a German social scientist remembered for his struggles for the oppressed working poor of Manchester, England, published writings describing how inequalities in health outcomes were closely tied to social class and material deprivation,

and resulted in poor physical health, psychological stress and unhealthy behaviours (Engels, 1845).

***Determinants of Health in Canada: Past to Present***

In mid-nineteenth century Canada, disease outbreaks and deaths related to water and sewage practices were commonplace among early settlers and Aboriginal populations (Library and Archives of Canada, 2006). The sanitary reforms reduced death rates, while the creation of boards of health and improvements in public structure made significant improvement in general population health (Legislative Assembly of Ontario, 1901). At the turn of the twentieth century a range of health and social initiatives further improved overall population health and social well-being.

Universal hospital and physician services for all Canadian citizens was launched under the Medical Care Act in 1966 (Health Canada, 2005). In 1974, a federal government policy document, the Lalonde Report, was published. The report proposed that changes in personal behaviours and lifestyles (rather than healthcare services alone) would likely lead to greater improvements in health. Critics argued that the Lalonde Report's focus on personal responsibility for lifestyle choices tended to "blame the victim", while ignoring the broader social, economic and political contexts in which individual behaviours existed (Legowski & McKay, 2000). This provided an excuse for reduced state responsibility for resolving population health problems. Beauchamp (1976) states that "our fundamental attention in public health policy and prevention should not be directed towards...health behaviors....but rather towards breaking existing ethical and political barriers to minimizing death and disability." Despite receiving much criticism, in later decades the Lalonde Report became an integral element of

local and international health policy planning for health promotion initiatives (Public Health Agency of Canada, 2004)

### ***Broader Notions of Health***

As broader notions of health came to be recognized, health was seen as a resource rather than a state of being; it became clear that many social, cultural, economic, and political factors could influence health. This shift in approaches to disease causation, prevention, and treatment at national and global levels have improved our understanding of why health inequities exist and persist. The First International Conference on Health Promotion was held in Ottawa in 1986, which led to the signing of the Ottawa Charter. The Ottawa Charter advocates the securing of prerequisites of health, in addition to making political, economic, social, cultural, and environmental conditions favourable for health (Legowski & McKay, 2000). The Charter also emphasizes the importance of having the government, non-government sectors, and individuals working together in order to address health issues more effectively. In the 1990s the population health model was developed, reviving the public health policy tradition dating back to the nineteenth century. The population health model represented a systemic shift from individual healthcare models to a population based approach. It aimed to improve health by reducing health inequities and by considering the social and economic determinants of health. The new public health draws on the population health approach to health promotion and diseases prevention (Public Health Agency of Canada, 2004). Contemporary public health threats (such as health inequalities), changing health patterns, and advances in health knowledge have rendered the dominant health promotion framework obsolete (Awofeso, 2004). The new public health

addresses the major contemporary public health threats with a more holistic, multidisciplinary, and multi-sectoral approach.

### ***Health and Politics***

Following the Second World War, rapid social and economic reconstruction in Europe led to the emergence of the welfare state system of government, a system that ensured all citizens had access to health, social and economic resources (Bryant, & Raphael, 2010). In the 1970s, globalization and the rise of neoliberalism resulted in the decline of the welfare state. Neoliberalism gives precedence to the market economy. The liberal ideological construct sees the individual as being opposed to the collective, and freedom as being opposed to equality. (Wahl, 2011, pg. 5). The tenets of neoliberalism produce, or at least accept, greater socio-economic inequalities than the welfare state (Coburn, 2000). Inequalities in income, social class, health, and health-related determinants have been rising in most countries (Graham, 2004; Mikkonen, & Raphael, 2010). Today, the way states identify and address health inequalities is directly related to differences in political and economic structures and processes (Esping-Andersen, 1990; Saint-Arnaud & Bernaud, 2003). Social democratic countries such as Sweden, Norway, and Finland follow the principle of universalism and de-commodification of social rights—reducing health inequalities is high on public policy agenda (Raphael & Bryant, 2010).

### **The Social Determinants of Health in Modern Populations**

The social determinants of health (SDH) are the conditions of everyday life in which people are born, grow, live, work, and age, including the health system (WHO, 2015). There are 14 SDH that shape the health of Canadians, which are individual income and income distribution, unemployment and job security, employment and working conditions, education,

early childhood development, housing, food security, social exclusion, social safety net, health services, aboriginal status, gender, race, and disability (Mikkonen, & Raphael, 2010). The historical perspectives of Virchow, Chadwick, and Engels demonstrate the intersection of the social determinants and their implications on health, and this intersection continues to be a recurring theme in modern public health (Irwin & Scali, 2007).

### ***Income, Wealth and Social Status***

In recent years the association of socioeconomics with health has re-emerged as being of central importance to policy and practice. Longevity and quality of life are determined by the availability of sufficient material resources, which include assured access to such things as educational opportunities, food, housing, and healthcare (Raphael, 2014). Much of this access depends on secure income/wages and the conditions of and opportunities for employment, which are controlled by governing authorities through public policy decisions (Raphael, 2015). Social divisions in a society identify socioeconomic locations of an individual within hierarchies of power and determine access to resources (Commission on Social Determinants of Health [CSDH], 2008). Social gradient is a global phenomenon that determines people's vulnerability to ill health. It demonstrates the direct link of health to socioeconomic status: that is, the lower the socio-economic status of individuals, the worse their health (Commission on Social Determinants of Health, 2008). The effect of income on health represents the essentiality of income as a means of gaining access to social determinants of health and other societal resources.

### ***Neoliberalism and Determinants of Health***

Given the fact that health and its promotion are profoundly political (Bambra et al., 2005), it becomes imperative to understand political determinants of health and to act upon them, however uncomfortable or risky it may be (Navarro, 2007). The SDH are often discussed in government documents, speeches, and the media, but it is questionable to what extent such talks actually move beyond rhetoric. Supporters of neoliberalism claim that neoliberal policies have given rise to unprecedented economic and social well-being (Navarro, 2007). Their opponents, on the other hand, argue that such policies have caused declines in population health and well-being in several countries (Whitehead, 2008). In a neoliberal society, fundamentals of health such as food, housing, and education appear largely ignored in health policy in favour of policies promoting diet and fitness changes.

Ayo (2012) identifies five basic tenets of the neoliberal health agenda: rationality, minimal government intervention, market fundamentalism, risk management, individual responsibility, and inevitable inequality as a consequence of freedom of choice. The first tenet means that government action to implement public policies that may increase opportunity to SDH and reduce health inequalities is minimal. Instead of investing in the prerequisites of health, such as income, food and shelter, as urged to by the Ottawa Charter for Health Promotion, the neoliberal health promotion agenda focuses on individualistic lifestyle choices, as advocated in the Lalonde Report (Ayo, 2014). To empower citizens to become responsible, self-governing citizens, certain lifestyles and behaviours are promoted. Health conscious citizens are expected to adopt these lifestyles by investing their time and money into healthy living choices. The inequalities in health and socioeconomic factors that arise out of freedom of choice are representative of the neoliberal 'healthy' society (Ayo, 2012).

### **Health Inequality in Canada**

In recent decades, the wealthy developed economies of the world have experienced remarkable health gains in life expectancy and a reduction in infant mortality and death from heart attack and stroke conditions (Organisation for Economic Cooperation and Development, 2011a). These health gains are attributed to improvement in living standards and lifestyle, better education, and greater access to quality health services over the decades. In five decades, life expectancy in Canada for both men and women improved by 10 years, averaging at 79.3 years for men and 83.6 years for women in 2011. Infant mortality also improved significantly, dropping from 27.2 deaths per 1,000 live births in 1961 to just over 4.8 live births in 2011 (Organisation for Economic Cooperation and Development, 2014). Despite Canada's role as a global champion of public health, health promotion and population health, Canada has been slow in implementing public policies that address health inequities (Bryant, et al., 2011). It is no coincidence that, in the last three decades, Canada has been susceptible to the neoliberal resurgence (Bryant, et al., 2011).

#### ***Where are the Health Inequalities?***

Canadians in general appear to be living longer and better quality of lives. However, a closer look reveals that the health of individuals has improved less than one might think (Labonte, et al. 2010). Aggregate health data obscures large health differences within subpopulations on health measures such as life expectancy, infant mortality, and prevalence of chronic disease (e.g., diabetes mellitus or heart disease) (Conference Board Canada, 2008). There are significant differences in multiple health indicators between different groups of people living in Canada, depending on their sex/gender, race/ethnicity, income level, education, and

neighbourhood (Canadian Population Health Initiative, 2006). Canada's relative standing in life expectancy and infant mortality has been steadily declining (Wilkins, 2007) compared with other countries in the Organisation for Economic Co-operation and Development (OECD). Infant mortality and low birth weight rates are important measures of children's health and of overall societal health. Canada's ranking in infant mortality rates has slipped from 10th position in 1980 to 27th in 2010 (OECD, 2011a).

Marginalized groups/communities in Canada face unique conditions and barriers to healthcare and social resources. Being a visible minority, female, Aboriginal, recent immigrant, of working class, and/or having a disability determines the exposure to the quality of SDH and their resulting health outcomes (Smylie, 2009). Life expectancy in the Yukon, Nunavut, and Northwest Territories is 75.1 years, significantly less than life expectancy in the wealthier province of British Columbia, whose life expectancy is 81.7 years (Statistics Canada, 2012). Similarly, Canadians living in rural areas exhibit poorer health than those in urban centres (Mitura, & Bollman, 2004). Aboriginal people's health is well below that of the rest of Canadians; they have significantly lower life expectancy (Smylie, 2009), much higher infant mortality, much higher rates of mental health conditions, and shockingly high suicide rates (5-6 times higher) (Health Council of Canada, 2005).

### ***Health Inequalities and Income***

Income is the strongest social determinant of health (Tjepkema et al., 2013; Kawachi, & Kennedy, 2002). The level of income determines the overall quality of life, which includes access to fundamental human needs such as food, housing, education, and healthcare, and it also affects physical and mental health, and health behaviors (Galobardes et al., 2006). Research on

neighbourhood income and health shows that the death rates, suicide rates, infant mortality rate, incidence of low birth, and prevalence of diabetes are significantly higher in neighbourhoods with lower incomes (James, et al., 2007; Wilkins, 2007).

### ***Inequalities in Housing***

Given that access to food and housing is determined by income and its distribution (Bryant, et al., 2011), people living in poverty are more likely to experience food insecurity and live in problematic housing situations. They are forced to choose unsafe, or unhealthy housing/accommodation (Laird, 2007). Rising housing costs, retrenchment of welfare, and further withdrawal of investment in subsidized housing has resulted in an alarming number of poor Canadians finding themselves homeless. (Gaetz, et al., 2014; Hwang, 2001; UN General Assembly Human Rights Council, 2009). The mass homelessness or ‘national crisis’ has become a significant problem in Canadian cities (Gaetz, et al., 2014; Hwang, 2001). People who are homeless face significant barriers to accessing health care (Hwang 2001; Public Health Agency of Canada, 2006). They are at increased risk of mental and physical illness, increased risk of dying prematurely, and often become victims of violence (Shortt, et al., 2006).

### ***Inequalities in Children’s Health***

Childhood poverty and access to early childhood education and care is a much debated issue in Canada. One out of every nine children in Canada still lives in poverty while one in every four children belonging to a First Nations community grows up in poverty (Rothman, 2009; Assembly of First Nations, 2006). Canada ranks below many rich western countries on many indicators of children’s health (Organisation for Economic Cooperation and Development, 2011b). The health of children is closely tied to the quality and distribution of a wide range of

SDH in Canada. The rise in poor health outcomes for children is preventable; however, the encroachment of the market economy into public services has resulted in a decline in children's health. For example, daycare has become increasingly dominated by market forces and is therefore not available to modest and low-income households (Bryant, 2015). Inequalities by neighbourhood income appear to be correlated with infant mortality rates (Wilkins, 2007). Infant mortality rates in the poorest 20% neighbourhoods were seen to be 40% higher than in the wealthiest 20% of neighbourhoods (Wilkins, 2007). These inequalities and decreases in health can be attributed to differences in income and the unequal distribution of the social determinants of health.

### ***Inequalities in Healthcare***

Quality health care services are a SDH as well as a fundamental human right. Access to healthcare and medicare coverage are not evenly distributed in Canada. People in the lowest income quintile have more health problems than those in upper quintiles, and yet they face more barriers in accessing healthcare (Turcotte, 2014). They are also less likely to have a regular family doctor or to see a specialist when needed, and are generally less likely to use healthcare services (Van Doorslaer et al., 2006). By contrast, those in the upper income quintiles are able to access a wide range of quality healthcare. Researchers found that wealthy educated Canadians navigate both public and private healthcare systems with ease. They have a greater voice and are able to elicit specialist referral from general practitioner gatekeepers when they need it, and they also receive better care in hospitals (OECD) Economic Surveys: Canada, 2010). In many wealthy, developed nations drug costs and a range of health services are covered by the public

healthcare system (Bryant, 2015). Canadian medicare does not cover drug costs nor dental care, and does not equally cover home care across the provinces.

### **Discussion**

Canada has a tradition of theorizing about tackling health inequalities; however, effective action, especially public policy action, has been rather scant (Raphael, 2012). With the advent of neoliberal policies in the Canadian political landscape, many of these traditions have been altered or even taken away (Raphael, 2000). Public policy decisions are mostly shaped by political and economic forces. Thus, it is critical to focus on public policies that determine the distribution of economic and social resources (Raphael, 2010). This necessitates an analysis of the economics, politics, ideology, and power balances which influence public policy making. The shift in political and economic ideology and the growing influence of the business and corporate sector has increased inequalities in health and social wellbeing. To compete in expanding globalized economy, some welfare states retrenched welfare, reduced government spending on health and social welfare, and adopted labour market restructuring (Bryant et al., 2010). Governmental preference for redistributive public policy, such as taxes and transfers, can profoundly decrease income inequality and improve the provision of public or social services (Mackenzie, and Shillington, 2009).

The issue of addressing health inequalities requires identifying the sources of health, and how their distribution affects health and how decisions regarding their distribution are made. The political economy framework explains how the relative power of the markets and political ideology influences public policy formulation and, ultimately, the health of populations. It also informs us of how resources are distributed and how health inequalities are created. The specific

social and economic conditions that people grow up in affects their lives and determines their risk of illness and overall health. Exposure to health strengthening and health threatening conditions are associated with income and wealth (Raphael, 2015). Behind housing, education, food, recreation, healthcare, opportunities in life, and a wide range of material goods lies income and wealth. And behind income and wealth lie other forms of power. The quality and availability of the social determinants of health to individuals, families, and populations are usually a result of public policy decisions.

A rights-based approach offers a concrete tool for restructuring public policies, to organize systems and services, and to develop actions that promote better health outcomes (De Negri Filho, 2008; London, 2008). Taking a rights based approach to health strengthens its political nature and can influence public policies targeted to respond to health and social needs. Three aspects of health make it relevant for a human rights approach: the indivisibility of civil rights from political rights and socio-economic rights; the potential loss of agency which populations with vulnerability to human rights violations can incur; and the need for accountability for protections and freedoms (London, 2008). A rights-based approach must seek to give voice to those who are vulnerable (individuals or groups whose rights have been violated) and enable them to exercise their agency in choices and capabilities. In situations where human rights are threatened, human rights standards can define who is a rights holder and who is a duty bearer. They can also hold states accountable for the realization of these rights and facilitate redress for violations of these rights to health (De Negri Filho, 2008; London, 2008). In an increasingly globalized environment, global trade rules shape the context in which national

policies and programs operate. These conflicting forces constrain national and local decision-makers.

### **Conclusion**

The drift of policy paradigm from a welfare state ideology to liberal welfare ideology has affected the quality and distribution of SDH in Canada and progressively increased health inequalities over the past decade. The policy shifts have resulted in reductions in public spending, changes in labour and employment laws, and changes in tax structures. It is time for a serious response from policy-makers, the media, and the public in addressing health inequalities. Addressing the root cause or the “causes of the causes” of inequalities in health will help to get upstream in the trajectory of human illness and health. The political economy framework helps to point to the causes and consequences of inequalities in health. Unless concrete initiatives are taken to reduce and ultimately eliminate inequity in all spheres of life, these differences may multiply and cripple societal progress and development. When implementing policies and programs, state officials must take into account that the intersection of politics, economics, social factors, power, influence, wealth and health often shape health and its determinants. Integration of human rights into our health and public policies may provide many opportunities to address key challenges in health, and in this way reduce social and income inequalities and optimize the health of population

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