

Social justice and human rights as a framework for addressing social determinants of health

Final report of the Task group on Equity, Equality and Human Rights

Review of social determinants of health and the health divide in the WHO European Region

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It reflects the findings of an interdisciplinary research group, consisting of researchers from both public health and law. A major obstacle in this research has been to overcome differences between these two disciplines, especially for human rights. We strongly feel that such differences, which could lead to misunderstandings, can only be overcome through collaboration and cross-fertilization to enhance the mutual understandings of our frameworks and tools. To ease the reading of this report, and to avoid confusion about the various interdisciplinary terms used in this report we have inserted a glossary of terms.

The main text has been written by Karien Stronks (Professor of Social Medicine, Department of Public Health, Academic Medical Centre, University of Amsterdam, Netherlands) (all chapters), Brigit Toebes (Associate Professor of International Law, University of Groningen, Netherlands) (Chapters 3 and 4), Aart Hendriks (Professor of Health Law, Leiden University/Leiden Medical Centre, Netherlands) (Chapter 3), Umar Ikram (PhD student, Department of Public Health, Academic Medical Centre, University of Amsterdam, Netherlands) (Chapter 4) and Sridhar Venkatapuram (Wellcome Trust Fellow (Ethics), London School of Hygiene & Tropical Medicine and Affiliated Lecturer, Cambridge University, United Kingdom) (Chapters 1 and 2). We are grateful to the following people critically reviewing earlier drafts of the main text: Audrey Chapman (University of Connecticut, USA), Mariël Droomers (Academic Medical

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Karien Stronks
Task Group Chair

Availability, accessibility, acceptability and quality	a set of principles recognized in the public health and right to health framework defining the conditions for health service provision
Accountability	the process of holding governments and other actors to account for their actions
Capability	set of lives among which an individual can choose a particular life he or she wants to live
Capability to be healthy	opportunity to lead a healthy life
Core obligations	minimum obligations inherent in, in particular, economic, social and cultural human rights
Free choice	right to exercises one's freedoms in any manner one might choose without interference from others
Health inequalities	differences in health status or in the distribution of determinants of health between population groups
Health inequities	health inequalities that are considered unjust and avoidable
Human rights	universally applicable legally binding norms set forth in international treaties
Human rights approach	using human rights law to address certain (policy) issues
Human rights law	the aggregate of human rights treaties as recognized at the international level
Human rights mechanisms	international and national procedures and other mechanisms for holding states accountable for non-compliance with human rights
Human rights obligations	(state) undertakings flowing from internationally guaranteed human rights
Libertarian paternalism	supporting people in making healthy choices – also called nudging
Non-discrimination	health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds
Positive freedom	individuals being able to pursue freedom, also called freedom of choice
Public health	the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private, communities and individuals
Respect, protect, fulfil	obligations (state undertakings) generally recognized as flowing from each human right
Right to health	a human right guaranteeing health; belonging to the category of economic, social and cultural rights
Right to life	a human right guaranteeing respect for life: belonging to the category of civil and political rights
Social determinants of health	circumstances in which people are born, grow up, live, work and age, and the systems put in place to deal with illness, in turn shaped by a wider set of forces: economics, social policies and politics
Social justice	justice exercised within a society
Underlying determinants of health	conditions for health as recognized in the human rights framework
Vulnerable groups	groups generally recognized as being subject to marginalization and denial of services

Conclusions and recommendations

Social justice

- The values of “equal concern and respect” and “freedom” are central to European countries. Against this background, the capability of individuals to be healthy should be a central consideration of social justice in these countries. This principle can be justified as part of the principle of maximizing individual freedom of choice and requires that every individual have the opportunity to be as healthy as possible.
- Realizing this principle requires governmental action. The responsibility of governments is to create conditions that enable individuals to be as healthy as possible. This demands such a distribution of social determinants of health – to the extent that they can be controlled by human beings – that every individual has the same possibility to lead a healthy life.
- The broad consensus felt in European societies regarding the injustice of health inequalities contrasts with a lack of consensus regarding the injustice of the distribution of determinants underlying health inequalities, such as income distribution. Ignoring this dualism in moral judgement might lead to a lack of legitimacy of policies tackling health inequalities. To increase the legitimacy of policies tackling health inequalities, the importance of equal opportunities to achieve health should be discussed in relation to other social values, such as welfare.
- Further, the tension with the ideology of free choice and individual responsibility is a clearly recognizable issue in public debates on health inequalities. Starting from the capability approach, society should try to remove barriers for free choice, to prevent differences in health behaviour that are rooted in unequal circumstances from arising. In other words, respect for freedom requires conditions that make freedom possible for most members of society. This might go along with restriction of individual freedom: soft forms of paternalism such as taxation on smoking might be justified. If people still can make other choices, this form of paternalism, also called nudging, seems even compatible with libertarian principles.

Human rights

- Out of the principle of equal opportunities to be healthy arise rights and claims, with both a moral and a legal component. As legally binding obligations for governments, human rights should play a steering role in drafting new laws, programmes and policies. Subsequently, if governments fail to realize these obligations, human rights law offers a legally binding framework for holding governments accountable for human rights violations before both national and international judicial and quasi-judicial bodies.
- The human rights framework offers a framework for addressing the broad range of social determinants of health and health inequalities. The human rights that are relevant in this context vary from the civil and political rights under, inter alia, the European Convention on Human Rights and Fundamental Freedoms and the International Covenant on Civil and Political Rights, to the various economic, social and cultural rights under, inter alia, the European Social Charter and the International Covenant on Economic and Social and Cultural Rights, as well as the non-binding United Nations General Comments.
- The key human right in this context is the right to health, as recognized at both the European Union and the WHO European Region levels. This right not only concerns accessing health-care services but also realizing the underlying determinants of health, which is somewhat in accordance with the approach of the social determinants of health.
- The underlying determinants of health as recognized under human rights law, however, insufficiently reflect the notion of the causes of the causes of health. To a certain extent, we can address this gap by using other human rights (such as rights to housing, food, social security and education), but the notion of the causes of the causes is still broader and more sophisticated, and the human rights framework must in this respect draw inspiration from the public health framework.

- In this report, we identify several tools that can be used for identifying the human rights obligations of states in connection with health inequalities. These include a set of guiding policy principles (availability, accessibility, acceptability and quality) for the right to health, indicating that all health-related services have to be available, accessible, acceptable and of high quality.

- Available cases, several of which are described in this report, indicate that the human rights framework has the capacity to effectively hold governments accountable for the adverse health effects of social determinants. The possibilities to use the human rights framework by civil society, legal practitioners and governments to promote policies to address health inequalities should be further explored.



Executive summary

Most people place very high value on enjoying good health. Consequently, it is generally regarded as unfair that certain groups within society (such as people with lower socioeconomic status) do not enjoy the same level of good health as others. The unfairness or injustice is perceived to be even more acute if inequalities in health correspond with the unequal distribution of other socially produced goods such as income, access to educational opportunities, built environments and opportunities for social participation.

Based on these arguments, the public perception that health inequalities are unjust seems to be widespread across societies. Nevertheless, there is also much scepticism about the progress in implementing actual policies to reduce health inequalities. In other words, there seems to be a gap between rhetoric and performance. This report addresses two issues relevant for closing this gap in translating rhetoric into actual policies: why health inequalities are unjust and how normative arguments can be translated into policy, particularly by using the framework of the human right to health.

Why are inequalities in health unjust?

The view that inequalities in health status are unjust is widely held in European countries. In other words, inequalities in the health status between certain groups in society are considered unjust if the health status of specific groups is worse than what is experienced by others. However, this moral claim to a certain (minimum) health status by itself is problematic. Such a claim does not consider the distribution of other social goods that have an important role in causing good health, such as income distribution or the social architecture surrounding health behaviour. The broad consensus in European societies regarding the injustice of health inequalities does not seem to extend to other social goods being determinants of health. Thus, public health, health care and social policies aimed to improve health might incur costs that conflict with the realization of other goals in society. In addition, in many western

European countries there are increasing references to the principle of free choice and corresponding individual responsibility as guides to public health policy. Such a focus on individual responsibility can appear to conflict with approaches to social justice as well as the related principle of collective responsibility for public health.

Ignoring the parameters of the moral indignation regarding health inequalities in public political debates may lead to a lack of legitimacy of policies tackling health inequalities and may contribute to sustaining the aforementioned gap between rhetoric and performance. We therefore argue that the importance of health equity should be discussed in relation to other social values; health inequalities are not the only moral concerns of social equity and justice.

Equal capability to be healthy

In Chapter 2, we argue that the capability of individuals to be healthy must be a central consideration of social justice. Conceived as equal opportunities to achieve health, this capability principle can be justified as part of the principle of maximizing individual freedom of choice and requires that every individual have the real opportunity to be as healthy as possible. The capability to be

healthy does not require everyone to have the same level of health. It instead demands a fair distribution of determinants of health to the extent that they can be controlled by human beings; that every individual has the same possibility to lead a healthy life. Given real opportunities, the individual reserves the right to decide whether to realize their capability to be healthy or not.

The capability approach broadens the focus from solely inequalities in health outcomes to include the inequalities in determinants of health. As such, it fits well with the approach of social determinants of health and health inequalities, understood as the conditions in which people are born, grow, live, work and age. It also does justice to the principle that modern societies are not supposed to

privilege one conception of “the good life” over another. Instead, each individual has the right to have his or her own conception of the good life, and having the capability to be healthy is a prerequisite for this. In this argument, health has value on its own, but it can also be seen as instrumental to other values, such as social participation.

Tension with the ideology of free choice and individual responsibility

Even if inequalities in health are considered unjust, conflicts with other societal values might still arise. One of these tensions relates to the ideology of free choice and individual responsibility. Public health policies are increasingly being criticized for being (too) restrictive of the choices of an individual related to specific types of health behaviour, such as smoking or drinking alcohol. In addition, right-of centre governments in western European increasingly use this argument for not pursuing certain public health policies, such as antismoking policies for the general population and lower socioeconomic groups in particular. What does the moral claim to the capability to be healthy say to this type of reasoning? Within the capability approach, health and free choice are inextricably linked. For capability represents the real, practical freedom of an individual to choose between the actual lives he or she could live. Health could therefore in this approach be considered as an element of freedom or a type of freedom. Thus, society contributes to the freedom of the individual by promoting the capability to be healthy

for all individuals. Freedom of choice in this approach is thus automatically linked with support from the government: government has a significant role in creating conditions for individuals being able to make free choices.

In addition, even if health behaviour is considered a free choice, interfering with free choice can be justified on a paternalistic argument: interference for the individual’s own good. Examples include taxation on alcohol or cigarettes, which might reduce smoking and heavy drinking in groups with lower incomes in particular. These forms of soft paternalism nowadays are framed in the language of nudging, also called libertarian paternalism: supporting people to make healthier choices by designing environments such that individual choices are preserved while overcoming the various barriers that prevent people from acting in their own best interest. The argument in these cases seems to be that, if people can still make other choices, it is compatible with libertarian principles.

Tension with other policy sectors

A second tension that is clearly recognizable in debates on tackling health inequalities is between the equal capabilities to be healthy and central aims of other policy sectors, such as economic policies. Improving the income situation of lower-income groups to realize equal capabilities to be healthy might, for example, conflict with the aim of most governments in Europe to reduce government spending. The capability to be healthy is clearly not the dominant perspective in income or economic policies. How should we weight economic goals against equal capabilities to be healthy? The capability

approach in itself does not propose any specific formula for policy decisions. This approach should in that sense be considered an open theory, with the open spaces to be filled in by public debate. The outcome of such a debate might differ between societies, depending on historical and cultural contexts. Nevertheless, most democracies in Europe are committed to ensuring that all citizens are above a threshold of basic capability. The public debate, in that case, should be about how high (or low) a specific threshold should be.

How can the human rights approach help us to translate these normative arguments into policy?

Individual moral claims or rights arise based on moral reasoning, such as that developed in the first section of this report. To paraphrase Norman Daniels (1), rights or claims are the moral fruits that are harvested from theories of justice. This report discusses the value of the human rights approach in supporting policies addressing health inequalities.

In this respect, we identify two issues. First, we must identify which human rights are relevant in the context of health inequalities and what legal human rights obligations of governments result from these rights. Chapter 3 of this report identifies the

human rights responsibilities of European governments in this respect. The central issue here is whether human rights law offers a framework for addressing health inequalities, and if so, which human rights instruments are especially relevant. Second, the question arises of how governments can be held accountable under human rights law when they fail to realize the responsibilities identified in Chapter 3. Chapter 4 therefore searches for accountability mechanisms and discusses examples of successful cases in which governments were held to account for such failures.

Human rights as a framework for addressing social determinants of health

Based on the analysis in Chapter 3, we conclude that the human rights approach offers a useful framework for addressing health inequalities. Central to this approach is the right to health.

It is explained that this right not only concerns accessing health-care services but also improving the underlying determinants of health, which is very much in accordance with the approach of social determinants of health. The human rights that are relevant in this context are referred to in a wide range of human rights treaties that have been adopted at the United Nations level and within the framework of regional human rights systems. These include rights to housing, food, social security and education, as stated in General Comment 14 on the Right to the Highest Attainable Standard of Health. However, in the current human rights framework, the underlying determinants of health are not completely congruent with the social determinants of health. In other words, the literature on underlying determinants in the right to health insufficiently reflects the full extent of the causes of the causes of health. To a certain extent, we can address this gap by using other human rights.

The right to health, like all human rights, is

subject to resource availability, meaning that higher-income countries can do more than lower-income countries. The right to health is therefore subject to progressive realization, meaning that governments are required to progressively work towards its realization. States are to take steps to the maximum of their available resources. To ensure a bottom line or minimum level of service provision below which no government should fall, General Comment 14 outlines several core obligations that states have to ensure under all circumstances. Among the core obligations are several services that address the underlying determinants of health. This means that, irrespective of a state's available resources, based on the right to health, it has to guarantee minimum essential food, basic shelter and education concerning the main health problems.

As legally binding obligations for governments, human rights should play a steering role in drafting new laws, programmes and policies. Subsequently, if governments fail to realize these obligations, human rights law offers a legally binding framework for holding governments accountable for human rights violations before both national and international judicial

and quasi-judicial bodies. Chapter 4 of this report elaborates on the possibilities that the human right framework offers for holding governments accountable for tackling health inequalities. We chose to focus on the situation in which governments fail to realize equal opportunities to be healthy. More

specifically, we analysed cases that addressed social determinants of health within a human rights perspective. Demonstrating how human rights play a role in developing policies, such as in drafting new laws, goes beyond the scope of this report.

Holding governments accountable for tackling health inequalities

The analysis in Chapter 4 shows that a wide range of rights can effectively be used to address harmful social determinants of health, thus affirming the interdependence of rights. The rights applied varied from the civil and political rights under, inter alia, the European Convention on Human Rights and Fundamental Freedoms, to the various economic, social and cultural rights under, inter alia, the European Social Charter and the International Covenant on Economic and Social and Cultural Rights, while reference was even made to the non-binding United Nations General Comments.

To measure the effectiveness of applying human rights in these cases, we first looked at whether the cases under scrutiny were effective in creating a sense of accountability for the issues they addressed. Clearly, in all the cases we examined, governments were held to account for harmful social determinants. There were, however, differences in terms of effectiveness between types of accountability mechanisms. We see a distinction here between litigation and actions by local nongovernmental organizations (NGOs) on the one hand and more general actions (reports by national and international bodies) on the other. Individual court cases as well as actions by local NGOs appeared to have led to very concrete improvements for individuals or groups that were directly affected by the human rights violations. In addition, whereas these types of accountability mechanisms in principle only benefit individuals or affected groups, sometimes court cases can have a spillover effect as well. On the other hand, an advantage of more general actions, such

as the publication of a human rights report, is that they can more effectively address the problems affecting a larger group of people, a general health problem or issues affecting the population at large. The cases we analysed show that this kind of report addressing social determinants of health can successfully draw attention to a particular issue. The concrete impact and results were, however, less concrete and more difficult to measure.

Ideally, of course, using the human rights framework makes a change for a larger group of people, a population group or society at large to be able to reduce health inequalities. From the cases we studied, we carefully conclude that the types of actions that were directed at a wider group of people in principle had a measurable impact or social outcome. Their actual impact is, however, difficult to establish, and further empirical analysis has to be done to actually support this claim.

Overall, based on our assessment of several case studies, we conclude that the human rights framework has the capacity to effectively hold governments accountable for harmful social determinants of health. Given the moral arguments for the injustice of health inequalities, human rights might invite and encourage governments to take action to tackle health inequalities. As such, it might be a useful instrument to argue for implementing policies to tackle health inequalities. We hope the case studies we presented in this report will act as a source of inspiration for various actors involved in these processes, such as civil society, legal practitioners and governments.

I. Introduction

Vast research indicates that there are wide health inequalities between and within countries, including European countries. An extensive study by Mackenbach et al. focusing on 22 European countries (2) demonstrates that, in all countries under scrutiny, the rates of death and poor self-assessment of health are substantially higher in groups of lower socioeconomic status. Responding to increasing concern about such widening inequalities, in 2005 WHO established the Commission on Social Determinants of Health to provide advice on how to reduce them. The Commission on Social Determinants of Health produced its final report in August 2008 (3). The report asserts the need to go beyond

the contemporary concentration on the immediate causes of diseases and include focus on the causes of the causes: the fundamental structures of social hierarchy and social conditions that determine where and how people live, work, are raised and educated which then subsequently determine people's state of health (3). The Commission on Social Determinants of Health made three overarching recommendations for all actors to reduce health inequities: (1) improve daily living conditions; (2) tackle the inequitable distribution of power, money and resources; and (3) measure and understand the problem and assess the impact of action. Within these areas of action, the Commission identified a further 12 areas for social action (Table 1).

Table 1. The objectives of the Commission on Social Determinants of Health

Improve daily living conditions	1) Early childhood development and education 2) Healthy places – the living environment 3) Fair employment and decent work 4) Social protection across the life course 5) Universal health care
Tackle the inequitable distribution of power, money and resources	6) Health equity in all policies 7) Fair financing 8) Market responsibility 9) Gender equity 10) Political empowerment 11) Good global governance
Measure and understand the problem and assess the impact of action	12) Knowledge, monitoring and skills

The report concludes that health inequities within and between countries arise because of the unequal distribution of power, income, goods, and services as well as the circumstances of peoples' lives including their access to health care, education, their conditions of work and leisure, their homes and their communities (3). Conversely, improving these social circumstances might be an entry point for health policy to tackle inequalities in health.

Most people place a very high value on enjoying good health. Consequently, inequalities in health are generally regarded as unfair. More specifically, the fact that certain groups within society (such as people with lower socioeconomic status, ethnic minorities and stateless refugees) do not enjoy good health compared with others is regarded as unfair. The unfairness and injustice is perceived to be even more acute if inequalities in health also

correspond with the unequal distribution of other socially produced goods such as income, educational opportunities, built environments and opportunities for social participation. Injustice can be identified in the causal pathways between these social goods and health inequalities; in health inequalities exacerbating inequalities in these other valuable and valued goods; and in the clustering of inequalities in health and these other valuable goods leading to a life of disadvantage and low well-being.

Against these background arguments, the public perception that health inequalities

Since health is so highly valued as well as morally reasoned as being related to issues of fairness and social justice, public health professionals frequently assume that there is no need to explicitly justify measures to promote health in general and reduce inequalities in health in particular. Anything that might protect, sustain or improve health is considered to be right and worthwhile to do. However, public health, health care and social policies aimed to improve health might conflict with individual freedom or incur costs that could be used for realizing other social goals. Or they may even conflict with other aims of health policy such as achieving the greatest health gains within a population. In addition, the principle of individual freedom and corresponding responsibilities are increasingly being referred to in western European countries to guide public health policy. This increasing focus on individual responsibility can appear to conflict with various approaches to social justice as well as the related principle of collective responsibility for public health.

are unjust seems to be widespread across societies. Nevertheless, there is also scepticism about the progress in implementing actual policies to reduce health inequalities. In other words, there seems to be a gap between rhetoric and performance (4). This report addresses two issues relevant for closing this gap in translating rhetoric into actual policies. The first issue is to review why health inequalities are unjust and compel social action. The second issue is to show that these moral arguments can be translated into policy, particularly through using the human rights framework.

Why are health inequalities unjust?

Because of the numerous possible conflicts and related social choices that need to be made in health policy, explicitly discussing the moral justification of policies aimed at reducing health inequalities is important (5–7). Such meaningful and apparently conflicting concerns underlying health policies also show that the links between basic social institutions, social choices and health inequalities are deep and complex. We therefore need a compelling argument that health inequalities rise to the level of social injustice requiring social action including the expenditure of social resources. More generally, in democratic societies the debate about what makes a good society, which in turn can serve to guide social action and policies, should be a continuous one (8). This report contributes to this ongoing debate and considers first why health inequalities are unjust. When addressing this question, we draw on general theories of social justice as developed in a long tradition of political philosophy.

How can moral arguments be translated into policy?

In practice, the priority for tackling health inequalities should be settled in a deliberative political process. Such public deliberations will necessarily have to consider the question of how to translate the moral demands of justice in the field of health into social action. In other words, given the moral arguments about the injustice of health inequalities,

which arguments do we have that can encourage governments to take action to tackle health inequalities?

In this report, we discuss possibilities the human rights approach offers in advancing social action to reduce health inequalities. Several authors have explored the relation

between the social determinants of health and the human rights approach (9,10). Indeed, the Commission on Social Determinants has been criticized for the fact that its final report underdeveloped and understated the human rights approach (9). The Commission primarily based its work on the idea of social justice, stating that inequalities in health that are avoidable by reasonable social action are unfair: “Social injustice is killing people on a grand scale, and the reduction of health inequities, between and within countries, is an ethical imperative.” (11). This might indicate some scepticism regarding the usefulness of the human rights framework among public health experts. On the other hand, human rights lawyers may not yet have succeeded to adequately communicate the added value and efficiency of their tools. The aim of this report is to bridge this gap.

However, social justice arguments and the human rights approach to advancing social action to tackle health inequalities are not mutually exclusive. Whereas social justice theories provide ethical arguments as to why inequalities in health are unjust, the human rights approach can provide possibilities to practically promote social action to tackle health inequalities (12). In particular, the

fact that human rights law generates state accountability for the values that they were created to protect might offer promising opportunities for implementing policies to tackle health inequalities. As stated by the Commission on Social Determinants: “The right to health, as set out by the existing Special Rapporteur, Professor Paul Hunt, presents a compelling case for action on the social determinants of health.” (9).

As legally binding obligations for governments, human rights should play a steering role in drafting new laws, programmes and policies. Subsequently, if governments fail to realize these obligations, human rights law offers a legally binding framework for holding governments accountable for human rights violations before both national and international judicial and quasi-judicial bodies. This report surveys the possibilities and advantages that the human rights approach offers for producing policies addressing social determinants of health. We thereby focus on the situation that governments have failed to realize these obligations. Exploring actual cases of the role of the human rights framework in drafting new laws, programmes and policies goes beyond the scope of this report.

Outline of the report

This report is organized as follows. First, it analyses the normative issues that are important for tackling health inequalities (Chapter 2). This framework will specify moral arguments that can be used to argue in favour of governments being accountable for tackling health inequalities. Further, this report identifies the human rights instruments (international, regional or national) that offer opportunities to support policies that address social determinants of health in European countries. We will start with a framework for the human rights approach in relation to the

framework of social determinants (Chapter 3). This proposed framework is followed by a discussion of 15 examples of good practice in which the human rights approach has successfully been applied in policies to tackle health inequalities in European countries after human rights have been violated (Chapter 4). The conclusion of this report identifies the possibilities that social justice arguments and the human rights approach offer to hold governments accountable for health inequalities (Chapter 5).

2. The injustice of health inequalities

2.1 Introduction

Public health and social justice are inextricably linked. In fact, one could argue that social justice is the foundation of public health (13,14). More than 150 years ago, practitioners of social medicine recognized that characteristics relating to the organization of society and the interactions between people powerfully influence the causation of illness in individuals. Such insight can be seen in the work of Virchow, Engels, Chadwick and other founders of the discipline of public health. This long history of public health ensures that the value frame within which governance for health takes place includes social values such as human rights and social justice (8,15). In addition, promoting health is a generally considered a legitimate goal and duty of governments, given the high intrinsic value attached to health and its instrumental value to pursue other meaningful goals (16).

However, history and experience show that social commitment to the values of equity, fairness and social justice in the political arena is not enough to guarantee outcomes that are equitable, fair and just. Whereas the view that inequalities in health outcomes are unjust is widely held in European countries, this broad consensus does not seem to extend to the acceptability of policy measures tackling the underlying determinants of these health inequalities such as income distribution or the social architecture surrounding unhealthy behaviour. One might even argue that, during the past 10–15 years, the political support for the ideal of equality or equity in income or other social goods has decreased in many western European countries. We would argue that this discrepancy between the moral judgement

regarding inequalities in health outcomes on the one hand and the social determinants of these health outcomes on the other is one of the reasons for the aforementioned gap between rhetoric and performance regarding addressing health inequalities.

This dualism in moral judgement is inherent to the direct approaches to health justice (17). In direct approaches, a health status of certain groups in society is considered unjust if this health status is worse than what is experienced by others. Egalitarian arguments such as “everyone should have a fair opportunity to be as healthy as possible” and that “priority should be given to improving the health status of the worst off” are examples of such direct approaches. Further, in direct approaches, health, like other socially valued goods such as civil and political liberties and basic incomes, is considered as having independent value. Thus, it is considered separately, or in its own domain, from other valuable goods or relevant values in society (18). The implication of this type of reasoning is that any inequality in health is *prima facie* unjust or unfair in so far as it is avoidable (19).

Such a direct approach is based on a moral claim of individuals to health in itself. Although this seems to be aligned with the commonly shared value of health, such a purely direct value approach is unsustainable for several reasons. The first reason is related to the difficulty of arguments about (in)justice starting from a notion of the common good or a set of shared values. In this case, the starting-point of the common good would be the value of being as healthy as possible. Given the plurality of religious and moral

views in modern society, a fixed notion of the common good, seen as a particular state of affairs or a state of being that every individual should strive for, is implausible. As argued by John Rawls, among others, a conception of social justice has to show respect for diverse conceptions of life, and, indeed, incommensurable religious and moral values. Starting with health as a valuable good would be disrespectful to the individuals who do not share such a value.

Second, the fact that determinants of health are broad social factors is another reason against arguing for the injustice of health inequalities in isolation from evaluating other factors. That is, a direct approach may recognize these social determinants and move quickly towards changing them. However, such social determinants of health as income, employment and education are goods that people might have reason to value inherently and not just for their determining role in health. This means that we cannot evaluate or construct a theory of the justice of health inequalities in isolation from a more general theory of justice that provides guidance on the right distribution of these other valuable goods as well as health (18).

A third problem with relying wholly on the moral claim to health in itself is that it results in several dilemmas if it is translated into social action. The most prominent problem is the conflict with an approach that emphasizes free choice and individual responsibility. Several countries in western and northern Europe in particular exhibit a recent and clear shift from the ideology of collective responsibility for the welfare of the population towards individual responsibility

for one's own welfare (20). The rhetoric of individual responsibility is being used to guide and implement public policy in these countries in health and other domains. Within this ideology, inequalities in health are not *prima facie* seen as unjust. Instead, health inequalities across individuals and groups are seen as reflecting the consequences or outcomes of individual choices. Therefore, a logical consequence of the value attached to individual responsibility is that health outcomes, whatever they may be, are just outcomes as they reflect individual choices.

The moral claim to health status by itself, as its own domain, without considering other values that are considered important, might lead to a lack of legitimacy of policies tackling health inequalities and may further contribute to the aforementioned gap between rhetoric and performance. Pursuing health as the singular and most important social good may be blind to synergistic policies involving other social domains as well as be ineffective in engaging with political processes which often aim to pursue multiple social goals at any given time. Conversely, rather than focusing on health outcome equity as an isolated ideal, we can escape this impasse by discussing the importance of health equity in relation to other social values. In pursuing such a path, the following discussion places health equity into the broader context of theories and arguments that have been put forward as a moral basis for a just society. In contrast to the aforementioned direct approach, which looks first and foremost at health outcomes, these are called indirect approaches to health justice.

2.2 Health equity as part of a broader theory of egalitarian justice

Political philosophy has a long tradition of debates on the moral justification of equality and equal distribution of valuable goods. In discussions about health justice, we can draw on elements of those rich debates and theories of justice. Until relatively recently, the available arguments and theories of health justice tended to concentrate on equal entitlements to health care (1). This is clearly consequent to the fact that in some of these theories, like that of Rawls' theory of

justice, health is considered a natural good, something that individuals are simply born with and is subject to random luck over the life course. Equal entitlements to health care can in this conceptualization be seen as a social response to the periodic deficiencies in health among some of us. It is clear that such an approach does not sufficiently appreciate the fact that health is profoundly influenced by social factors throughout the life course, which is the central focus of the social

determinants of health approach. A theory of justice in general, and of health justice in particular, in order to be useful, should also recognize, evaluate and guide action on other determinants of health than health care, including the surrounding social and material conditions and health behaviour. Health care is profoundly important in relation to health, but it is not the only point to consider in pursuing health equity.

The concern with equality and inequality has been a central theme in political philosophy for most of the 20th century. A common starting-point for this theme is that, for any conception or theory of social justice to be plausible in the modern world, it has to treat human beings equally in some meaningful way (21). Such a starting-point, however, does not identify in what space societies should treat individuals equally. In other words, what goods are to be distributed fairly to guarantee that a society is just? Is this income, wealth, health, liberties or possibly well-being? What are deemed to be unjust inequalities vary according to a chosen theory's focal point of equality (the what). In regard to these focal points, three main approaches can be distinguished: capability,

resources and welfare. Secondly, theories also vary according to the how: how should we distribute the "what"? Regarding this aspect, what are deemed to be unjust inequalities vary according to a theory's chosen distribution rules: how things are distributed and to whom. Should this be absolute equality, equality up to a certain minimum, or some other pattern? Unjust inequalities then reflect a particular approach's valued goods being distributed, how they are distributed or both.

The discussion below examines both the "what" and "how" question in turn. We pursue the capability approach of Amartya Sen and Martha Nussbaum as a moral foundation of policies to tackle health inequalities. More specifically, we argue that the responsibility of the government to guarantee equity in health comes within the responsibility of guaranteeing every citizen equality of opportunities to plan and realize his or her individual life plan. If the latter is coherently justified, then the government obligation to pursue realizing equity in opportunities to be healthy follows logically from this.

Equalisandum: equality of the "what"

Recent philosophical discussions have identified three possible answers to the question of what should be distributed equally (also called: equalisandum). These include capabilities, resources and welfare. As previously stated, we pursue the capability approach of Sen and Nussbaum in the context of social determinants of health, thereby choosing capability as a focal point for social justice. There are several arguments for this.

Advocates of the capability approach argue that what matters for equality is not primarily individual welfare (a utility-based approach) nor the resources to which people have access (a resource-based approach). The utilitarian tradition counts only one thing as valuable related to mental well-being such as happiness or utility. The choice of a singular, fixed equalisandum related to subjective mental experience conflicts with the principle of equal respect for the moral worth of every human being, the aforementioned

starting-point of each modern theory of social justice. This fundamental principle implies that we should respect that individuals can have different goals to value, including, but not only limited to subjective well-being (happiness or utility). In contrast to the welfare approaches, the resource-based approaches focus on resources, such as income, as the crucial feature when assessing justice. Sen's critique of these approaches is that different people have different abilities for converting resources such as income into good living (21).

For example, income cannot be seen as an adequate indicator of poverty because what individuals can do with income varies with personal characteristics (such as disabilities), the characteristics of the social surroundings (such as social capital) and the physical (such as climate) environment. Poverty should reflect their abilities to lead flourishing lives they have reason to value rather than just their income. Further, as a result of

these differences in the abilities of individual human beings to convert resources, an equal distribution of resources would result in an unequal distribution of freedoms. This logical consequence of the resource approach conflicts with the principle of equal respect for the moral worth of every human being.

Sen goes on to argue that, rather than the target of equality being related to welfare, utility or amounts of resources, it should be freedoms – what individuals are able to be and do in their lives. There is a whole set of goals that people may pursue, and even within an individual life, these goals might change. Against the background conditions of equal freedoms, each individual should have the right to determine which life he or she wants to live: religious or not, healthy or not, hard working or not. This fits within the idea that freedom and showing respect for the equal dignity of every human are basic values of social justice theories (22). The capability approach argues that modern societies should help individuals to pursue their diverse conceptions of the good life. The role of social institutions in this approach is to create conditions that enable an individual to have real practical possibility of pursuing diverse life plans. In order to do so, we should focus on what people actually can do with resources to which they have access.

The concept of capability tries to capture the element of freedom of choice, which is central to the approach of Sen and Nussbaum. Capability may be defined as the sets of lives among which an individual can choose a particular life he or she wants to live. It should not be considered outcomes (such as being healthy), but as real opportunities, as things human beings are actually able to do in their lives. A capability set of an individual thus represents his or her actual freedoms to choose between the actual lives he or she could live. These different ways of living can be phrased in terms of alternative combinations of aspects of capability, or doings and beings. Examples of these include being adequately nourished and being able to pursue qualified education.

The real possibility to lead a long and healthy life becomes another condition for freedom of choice. In other words, the relevant set of capabilities includes the capability to be

healthy. This argument has been developed by Stronks & Gunning-Schepers (23) and more recently by Venkatapuram (12). The presence of this capability increases the range of life plans from which an individual can choose, whereas a restriction of this capability implies a reduction of the alternatives. Ensuring the capability to be healthy does not require everyone to have the same level of health. It instead demands a distribution of determinants – to the extent that they can be controlled by human beings – such that every individual has the same possibility to lead a healthy life. Given these opportunities, the individual reserves the right to decide whether to use the capability to be healthy or not. So the capability approach argues that, from the perspective of social justice, societies should ensure that every individual has the capability to be healthy rather than ensure that they are actually healthy. As a consequence, equality in the capability to be healthy may well result in differences in actual health status.

The justification of the desirability to pursue equality in health capability, perceived as equality of opportunities to attain health, is consistent with the value high-income societies attach to the principle of equal concern and respect and to positive freedom. Because the government is not supposed to promote a particular conception of the good life, each individual has the right to determine whether he or she lives a healthy



life. The only thing a government is entitled to do is to create conditions that enable an individual to make his or her own choice for a certain life plan (12,23). Nevertheless, this freedom of choice might be restricted by the need to respect the freedoms of other people. If an individual, by a certain doing or being, could harm the health status of other people or restrict the freedom of other people, social institutions might be allowed to go inside the individual's area of freedom to prevent people from doing the things they want to do.

One of the advantages of the capability approach is that it broadens the focus from just inequalities in health to also include the inequalities in determinants of health. As such, it fits well with the approach of social determinants of health and health inequalities (12). The claim to an equal distribution of (social) determinants to guarantee equal capabilities to be healthy is based on the shared values of freedom and equal concern and respect for each individual. It also does justice to the principle that modern societies are not supposed to promote a certain conception of "the good life". Instead, each

individual has the right to have his or her own conception of the good life, and having the capability to be healthy is one of the prerequisites for this. In this argument, health has value on its own, but it can also be seen as instrumental to other values, such as social participation.

Ideas underlying the capability approach are also visible in the assumptions of several public health policies in western European countries. For example, the Government of Sweden argues that the objective of public health policy is to create social conditions to ensure good health on equal terms for the entire population (<http://www.ncbi.nlm.nih.gov/pubmed/23341365>). The national committee that advised the Government of the Netherlands in 2001 started from the assumption that existing inequalities in health at least partly rank as unjust and that the government is responsible for reducing these health differences. This assumption was based on the argument that health should be seen as a precondition for the options open to individuals to structure their own life as far as possible according to their own ideas (24).

How should the capability to be healthy be distributed?

In the capability approach, reducing health inequalities can be considered a legitimate goal of governments based on the values of freedom and equal concern and respect.

What follows is the question: how should the capabilities to be healthy be distributed across individuals in society? What distribution pattern should we strive for? Advocates of the capability approach seem to have different views on the exact distribution a society should strive for regarding capabilities. In other words, no specific interpretation of equality is inherent to the capability approach; there are arguments for absolute equality, shortfall equality or equality until a sufficient level of a certain capability is achieved. Outside the capabilities approach, in the broader discussions about distributive justice, there are three general approaches to optimizing the distribution of goods (16).

Strict egalitarianism argues that we should strive for equality as an end in itself. The problem with applying this principle to health capability is that it does not take into account the average level of health or the capability to be healthy that is at stake. If the absolute level of the capability to be healthy can be higher for all groups if we accept higher inequality in health, it seems counterintuitive to choose a situation of smaller inequalities with lower absolute levels for all (16). In fact, the issue at stake here is the trade-off between equity and efficiency – with efficiency understood as maximization. Although some would argue that justice demands maximizing health despite increasing inequalities in health, it could also be argued that social justice in public health is about both maximizing health and health equality, the exact weight of which is to be determined in a fair deliberative process (25).

One solution for this trade-off that arises in strict egalitarianism has been put forth



in another conceptualization of equality: prioritarianism. Prioritarianism is a view that, given that our worry about inequality is derived from the prior value of the thing that is unequal, we should give priority (in this case in the distribution of capability to be healthy) to the people who are the worst off. Rawls' difference principle, which is his distribution rule that states that social and economic inequalities are allowable only to the extent that they benefit the least advantaged members of society, is an example of this category (26). Deviations from equality in valued social goods are allowed only when they improve the situation of the worst-off people. In case of a trade-off between equity and efficiency, this difference principle clearly provides guidance that we should give priority to improving the conditions of the worst-off people in society; equity trumps efficiency. That is, even when the same investments in groups other than the lower socioeconomic groups could result in higher benefits (such as more health capabilities), it cannot be done without also improving the situation of the worst-off people. Similar to the case of strict egalitarianism, it seems reasonable to argue that, in a fair deliberative process, social choice must determine whether prioritarianism should be given absolute priority or a trade-off should be made between equality and efficiency. This might depend, among other things, on the absolute level of the capability to be healthy in the groups that are worst off.

At least in the first instance, the third conceptualization of equality, which is sufficientarianism, seems to provide a solution for this dilemma. It argues that we

should guarantee that each individual has a sufficient quantity, in this case, of the capability to be healthy. Priority should be given, in this reasoning, to people below this threshold. Above that specific threshold level, people who are comparatively worse off do not have any stronger claims than those who are better off. Nussbaum's approach that identifies a set of basic human capabilities, for which minimum level thresholds are to be guaranteed, is an example of this form of egalitarianism (27). The crucial question, however, is whether we have arguments to adequately set the threshold at a certain level. For example, in the case of life expectancy, which arguments would be coherent for setting the level of sufficiency at 65, 50 or 80 years of life? If this threshold is arbitrary, one might question the usefulness of this approach. As with the other two distribution rules, a fair deliberative process to produce a widely supported threshold seems a reasonable solution.

Which of these approaches should be favoured? Although both Sen and Nussbaum argue for entitlements to basic capabilities, Sen clearly states that the capability approach in itself "does not lay down any blueprint for how to deal with conflicts between ... aggregative and distributive considerations" (21). This indicates that we should accept the fact that reasonable people might disagree as to which situation of inequality is worse than another. However, the above-mentioned principles of strict egalitarianism, prioritarianism and sufficientarianism might be useful in structuring the public or political debate on the just distribution to make a choice that is perceived to be the best in a specific context.

2.3 Conflicts with other societal aims

We have argued that the capability of individuals to be healthy must be a central consideration of social justice. Could we, consequently, argue that equity in this capability should have the highest priority in society? Implying that we can only speak of a just society if each individual has an equal opportunity to be healthy? From a public health perspective, the answer is yes, we could. That is, public health professionals appreciate that, without health, individuals

cannot pursue very much in their lives. Ill health places significant burdens on individuals, their governments and social institutions. Nevertheless, this is not a very realistic perspective. Political reality shows that realizing equity in the capability to be as healthy as possible might conflict with other values in society. An instance of this has already been illustrated by the aforementioned debate on trade-offs between equity and efficiency. Such conflicts result

in some clearly recognizable dilemmas in public health. Most prominent dilemmas seem to be those in which the principle of equal capability to be healthy conflicts

with addressing (a) other capabilities; (b) inequalities in underlying social determinants; and (c) the ideology of individual responsibility.

Conflicts between capabilities

Sen and Nussbaum's approach to social justice is useful in determining what basic capabilities are, but they do not offer much help in creating a hierarchy within these basic capabilities. What should society choose: equal opportunities to achieve health or equal opportunities to achieve gainful employment? The difficult choices occur when one basic capability has to be constrained for another one. The fact that health inequalities are inextricably linked to

social determinants that might be the subject of other capabilities (such as capability to have meaningful employment) and also that health inequalities might exacerbate inequalities in other capabilities makes these choices even more complex. In this case, difficult social choices entail that a transparent, informed and fair deliberative process is probably the most reasonable strategy to tackle this type of conflicts.

Conflicts with judgements on inequalities in underlying social determinants

The capability approach in fact captures the social determinants of health (28). As social determinants constitute important influences on health, the capability approach argues for an equitable distribution of the underlying social determinants. In that respect, within the capability approach, there might not be a conflict between the capability to be healthy and the distribution of underlying social determinants.

There might, however, be conflicts between the capability to be healthy and other arguments considered relevant for the distribution of social determinants, such as economic arguments. In high-income societies, some significant degree of inequality in goods such as income or employment is tolerated and sometimes even encouraged from an economic perspective. Should we then count as unjust health inequalities that result from inequalities in other social goods that we think acceptable or justifiable (29)? One might even take the argument one step further, however, and argue that inequalities in health might be an argument for redistributing the underlying social goods, even if we consider this underlying distribution in itself to be acceptable. Based on section 2.1, we might conclude that this is an example of a direct approach to health justice. These approaches provide an inherent moral claim to health and

health equality. In section 2.1, we argued that this approach is unsustainable for several reasons. This implies that simply referring to the impact of certain policy measures on the social determinants on health inequalities is not a convincing argument to give priority to health inequalities. How can the moral claim to the capability to be healthy help us to prevent a government from taking measures that might enlarge inequalities in the underlying social determinants?

To further explore this issue, it seems useful to conceptualize this reasoning as a debate between two types of arguments, like in the situation of the above-mentioned trade-off between equity (argument of justice) and efficiency (economic considerations). Arguing that inequalities in health are unjust, even if they result from a distribution of goods that is seen as desirable for economic reasons, implies that priority is given to justice considerations. This conflict might also be considered a conflict between the aims of different policy sectors. The capability to be healthy is clearly not the dominant perspective for income or economic policies. Improving the income situation of lower-income groups to realize equal capability to be healthy might therefore conflict with the aim of most governments in Europe to reduce, for example, the size of the public sector by lowering social benefits.

Arguing from the rationale of other policy sectors, such as the economic sector, there seems no reason to consider automatically as unjust the health inequalities that result from a certain distribution of, say, income that is seen as desirable. In the words of Sen (21): "... the use of the capability approach for evaluation does not demand that we sign up to policies aimed entirely at equating everyone's capabilities, no matter what the other consequences of such policies might be". Instead, the economic goals of these sectors should be weighted against other aims society might have reason to value, such as equal capability to be healthy. In this example, one could argue from the perspective of the capability approach that policy measures that serve economic goals

but enlarge inequalities in the capability to be healthy offend the value of equal concern and respect. They sacrifice the capability of some people for the benefit of the population as a whole. Although, as argued before, the capability approach in itself does not propose any specific formula for policy decisions, most high-income countries are committed to ensuring that all citizens are above a threshold of basic capabilities. We agree to ensure that people are not starving, have adequate housing, qualified education, etc. This implies that, this type of processes of weighting should also take into account the absolute level of capability for specific groups. The public debate, in that case, should be about how high (or low) a specific threshold should be.

Conflicts with the ideology of free choice and individual responsibility

Tension with the ideology of free choice and individual responsibility is a clearly recognizable issue in public debates about health inequalities. Public health policies are increasingly being criticized for being (too) restrictive of individual choices for specific types of health behaviour, such as smoking or drinking alcohol. In addition, right-of-centre governments in western Europe increasingly use the argument of individual responsibility for not pursuing certain public health policies, such as antismoking policies for the general population and lower socioeconomic groups in particular. These governments argue that the trends towards stimulating individuals to take responsibility for themselves are at odds with government responsibility for reducing socioeconomic inequalities in health.

Does the capability approach provide arguments against this reasoning? Within the capability approach, health and freedom are inextricably linked. By defining the equalisandum in the capability approach as capabilities, representing the actual freedom of an individual to choose between the actual lives he or she could live, health could be considered as an element of freedom. Thus, by promoting the capability to be healthy for all individuals, society contributes to the freedom of the individual. This implies that society should try to remove barriers for free choice and, in the case of socioeconomic inequalities in health, to prevent differences in health behaviour that are rooted in unequal

circumstances from arising. From this we might conclude that freedom as a value is central to the capability approach and that freedom in this approach is automatically linked with support from the government. Individual choices depend on the real choices individuals have, and government has a significant role in creating the conditions for individuals being able to pursue freedom. If these conditions are met, an individual is said to be free in the positive sense (30).

This shows that public health policies such as nonsmoking policies should not automatically be seen as policies that restrict individual freedom. Instead, if they create the conditions for individuals for having a real choice of being healthy, they extend individual freedom, in particular freedom of choice or positive freedom.

Does this imply that individual freedom does not impose restrictions on government policies at all and that government is allowed to take all possible measures to promote public health? This is not true either. First, within the capability approach, society is not allowed to impose a particular conception of the good life on its population or subgroups in the population. Living healthily can therefore not be judged as being superior to engaging in unhealthy behaviour where individuals have free choice. The most society should do is enabling all individuals, independently of socioeconomic background, to adopt healthy

behaviour. This implies that public health measures should be supportive but should not limit an individual choice about what constitutes the good life. Respect for freedom requires conditions that make freedom possible. As such, the capability approach “accommodates both the emphasis on individual health choices, and the possibility of non-arbitrary public health interventions that promote individuals’ capabilities to make choices regarding their own health goals” (31). On the other hand, in contrast to purely libertarian approaches to public health, the capability approach continuously encourages us to look beyond the individual choices to the social circumstances in which these choices are made. The simple fact that health-related behaviour differs between social strata indicates that this behaviour is shaped by social circumstances and therefore at least partly reflects unequal opportunities to be healthy.

Many factors might limit freedom of choice. To some extent, these factors can be determined empirically. Yet this judgement has a normative component too relating to the notion of free will. The notion of free will, placed in the context of the capability approach, refers to the ability of an individual to choose his or her own life plan. It might be argued that whether this ability is restricted or not depends on the type of constraint. In particular, some philosophers argue that being a member of a certain culture does not limit individual choice but instead enables people to choose (32). By being a member of a certain group, people will internalize that particular culture. The cultural norms that are common in that group will thus be transformed into individual preferences, and the norms thus contribute to who people are. In this line of reasoning, the availability of options to choose from presupposes a culture instead of considering culture as a factor that limits free choice.

Even if health behaviour is considered a free choice, this does not imply that there is no

In this chapter, we argued that the moral claim to health injustice should look beyond inequalities in actual health status. Although this seems to be aligned with the commonly shared value of health, there

justification for interfering with individual behaviour. If individual behaviour harms the health of others, restricting individual freedom might be justified (6). For example, this might be the moral basis for measures to ban smoking in public places. In addition, in some cases interfering with free choice can be justified on a paternalistic argument: for the individual’s own good. Examples include taxation on alcohol or cigarettes, which might reduce smoking and heavy drinking in groups with lower incomes in particular.

Forms of soft paternalism nowadays are translated into the language of nudging, also called libertarian paternalism (33): supporting people to make healthier choices by designing environments such that free choice is still preserved while overcoming the various barriers that prevent people from acting in their own best interest (34). The general principle of nudging is not new in public health: one could argue that it represents the older idea of making healthy choices the easy choices, framed under a new heading (35). Interesting, though, is the fact that neoliberal regimes have used this idea to justify specific public health measures instead of opposing these measures given their possible impact on individual freedom of choice. The argument in those cases seems to be that if people can still make other choices, it is compatible with libertarian principles (35).

Finally, the responsibility of the government for creating a healthy environment within which people can make healthy choices goes along with the idea of an individual being responsible for his or her own health. For within this environment, people have their own responsibility to use information about healthy behaviour and to maintain their health as best as they can. In addition, what results from free, informed choices is not considered social injustice in this perspective.

2.4 Conclusions

are several reasons why the moral claim that any inequalities in health are unjust is unsustainable. One is related to the difficulty of arguments about (in)justice starting from a notion of the common good, in this case

the value of being as healthy as possible. This might lead to conflicts such as seen in current debates in western European countries in particular, between advocates of tackling health inequalities and right-of-centre governments that argue against certain public health policies because they would restrict individual freedom. The moral claim to health status itself, without considering other important values, might therefore lead to a perceived lack of legitimacy for policies tackling health inequalities.

We argued instead that the capability of individuals to be healthy must be a central consideration of social justice, conceived as equal opportunities to achieve health. This principle can be justified as part of the principle of maximizing individual freedom of choice and requires that every individual have the opportunity to be as healthy as possible. The capability to be healthy does not require everyone to have the same level of health. It instead demands a distribution of determinants – to the extent that they can be controlled by human beings – such that every individual has the same possibility to lead a healthy life. As such, this capability approach perfectly fits within the social determinants of health approach. Given those opportunities, the individual reserves the right to decide whether to make use of the capability to be healthy or not, under the condition of free choice.

The justification of the desirability to pursue equality in health, perceived as equality of opportunities to attain health, is consistent with the value high-income societies attach to the principle of equal concern and respect and to positive freedom. Because the government is not supposed to promote a particular conception of the good life, each individual has the right to determine whether he or she lives a healthy life or prefers a lifestyle that is hazardous to his or her health. A government is entitled to create conditions that enable each individual to make his or her own choice for a certain life plan.

We also argued that, even if inequalities in health are considered the result of unequal capabilities to be healthy, and therefore unjust, conflicts with other societal values

might arise in addressing such injustices. The capability approach should in that sense be considered an open theory, with the many difficult choices to be discussed in public debate. The outcome of such a debate might differ between societies, depending on historical and cultural contexts.

The key issues in this public debate in European societies seem to concentrate on the issue of individual's free choice and responsibility and on conflicts between the capability to be healthy and other arguments that are considered relevant for the distribution of underlying social determinants of health, such as economic arguments for a certain income distribution. Within the capability approach, public health policies such as nonsmoking policies should not automatically be seen as policies that restrict individual freedom. Instead, since they create the conditions for individuals for having a real choice of being healthy, they extend individual freedom, in particular freedom of choice or positive freedom. With respect to conflicts between the equal capabilities to be healthy and central aims of other policy sectors, such as economic policies, we explored some arguments that the capability approach might offer in this debate. One could argue, for example, that policy measures that serve economic goals but enlarge inequalities in the capability to be healthy offend the value of equal concern and respect. They sacrifice the capability of some people for the benefit of the population as a whole.

These examples show that, in practice, the priority for tackling health inequalities should be settled in a transparent, informed and fair deliberative political process. Such public deliberations will necessarily have to consider the question of how to translate the moral claims of justice in the field of health into social action. In other words, given the moral arguments for the injustice of health inequalities, which arguments do we have to encourage governments to take action to tackle health inequalities? The next two chapters will explore the possibilities the human rights approach might offer in this implementation process.

3. The role of human rights law in addressing social determinants of health

3.1 Introduction

Out of moral reasoning, such as developed in the previous chapter of this report, arise individual moral claims or rights. To paraphrase Norman Daniels, rights or claims are the moral fruits that are harvested from theories of justice (1). This is why a simple list of rights, such as human rights, without a background theory, is seen as deficient for being unable to offer guidance in responding to the conflicts of rights and other wicked problems (12).

Now that we have pursued the capability approach as a moral argument for the injustice of health inequalities, the question arises as to the value of the human rights framework for encouraging governments to take responsibility for tackling health inequalities that can be argued to be unjust. Human rights law consists of a legally binding international value system that addresses matters of social (in)justice. In 2007, the Secretariat of the Commission on Social Determinants of Health recommended that the Commission adopt an international human rights framework within which to advance towards health equity through action on the social determinants of health. The framework document explains (36):

Human rights offer more than a conceptual armature connecting health, social conditions and broad governance principles, however. Rights concepts and standards provide an instrument for turning diffuse social demand into focused legal and political claims, as well as a set of criteria by which to evaluate the performance of political authorities in promoting people's wellbeing and creating conditions for equitable enjoyment of the fruits of development.

This chapter seeks to build a bridge between the findings of the Commission on Social Determinants of Health and the human

rights framework. An attempt will be made to connect the above-mentioned objectives of the Commission to concrete human rights norms and define concrete human rights obligations. In other words, in this chapter, we develop a human rights framework for governments for addressing social determinants of health and tackling health inequalities.

In accordance with Venkatapuram (12), we argue that human rights law can only be a supplementary tool for addressing the social determinants of health. Venkatapuram has objected to a trend of casting human rights against direct causal components of a model of causation and distribution of ill health and mortality. He argues that such an approach produces misunderstandings and undermines the important scientific analysis of causal pathways and distribution of impairments (12). This underlines that human rights law should never replace existing analyses of the social determinants of health.

It is also important to bear in mind that the human rights framework is currently not sufficiently equipped to address the social determinants of health. In this report, we pay some attention to how the human rights framework can be enriched by existing analyses on the social determinants of health. A concrete example concerns the development of indicators, for which there is considerable expertise in the public health field. An important more general question running as a thread through our analysis is whether the underlying determinants of the right to health and human rights law more generally are congruent with the social determinants of health from the report of the Commission on Social Determinants of

Health. Although we will discuss this more elaborately below, it is important to note as a starting-point that the social determinants of health are broader and go deeper than the underlying determinants of health.

The structure of this chapter is as follows. First, we outline the character and scope of human rights law and discuss the notion of accountability for human rights violations (section 3.2). Subsequently, we introduce the area of health and human rights (section 3.3) and make the connections with the social determinants of health (section 3.4).

3.2 What are human rights?

Ethical and legal demands

As mentioned above, human rights law is an internationally recognized value system. A starting-point for this document is the notion that human rights embrace both ethical and legal demands. To the extent that human rights are set forth in international treaties that have been ratified by states, human rights imply legal demands. This means that the legal human rights framework should inspire national legislation (the “steering role”), while states parties can be held legally accountable for not meeting their legal human rights obligations before national and international courts and other (quasi-judicial) bodies (see Chapter 4).

However, as underlined by Sen, from a broader perspective, human rights also

Next, General Comment 14 on the Right to the Highest Attainable Standard of Health (37) is used as a framework for our analysis (section 3.5). However, we will also go beyond the right to health framework and address the added value of the other rights, civil and political as well as economic, social and cultural ones: section 3.6 gives an overview of the goals of the Commission on Social Determinants of Health in connection with all the health-related rights and General Comment 14.

articulate ethical demands (28). This implies that human rights can be employed in various other ways, even when they are strictly speaking not legally binding in that context (28). This is an important notion, as not all the human rights documents and case law we use are, strictly speaking, legally binding (for example, General Comment 14 on the right to health). In addition, human rights law can offer a normative framework in a non-legal context. For example, human rights can provide normative tools for implementing new health policies; they can be used to hold private actors morally accountable for human rights violations; and NGOs can use them to draw attention to the issues they seek to address.

Character and scope

The core principle underlying human rights law is human dignity: meaning that human beings have an inherent right to respect and should always be treated as an end in itself. States and other actors in society are required to respect and to safeguard the human dignity of individuals, for example, by refraining from torture, by not allowing that individuals are exploited or exposed to hazardous substances, by taking measures to protect the privacy and health of individuals, by providing schooling and housing and by establishing a proper justice system.

Roughly speaking, a distinction has historically been made between two types of human rights: civil and political rights (such

as life, privacy and freedom of expression) and economic, social and cultural rights (health, food, education and housing). The right to health, a key right in this document, falls into the category of economic and social rights. It is, however, increasingly argued that all these human rights are interdependent and interrelated (38). In other words, all the rights support and reinforce each other. For example, the rights to health, privacy, information, education, food and housing are all important for protecting the health of individuals and the population as a whole.

The legal human rights framework comprises a wide range of human rights treaties that have been adopted at the United Nations

level and within the framework of regional human rights systems, which is, for Europe, the Council of Europe. Examples of such treaties are the International Covenant on Civil and Political Rights and the International Covenant on Economic and Social and Cultural Rights, which were both adopted at the United Nations level. At the European level, the most important human rights treaties are the European Convention on Human Rights and Fundamental Freedoms and the European Social Charter, both adopted within the framework of the Council of Europe.

By ratifying human rights treaties, states commit themselves legally to respect and realize the rights that are set forth in such treaties. As such, human rights are primarily claims of individuals towards their governments. Roughly speaking such claims can imply inaction or action on the part of governments. Inaction is sometimes called a state obligation to respect the right and translates into obligations not to infringe upon people's lives, their health, their privacy, their self-determination and their access to available services. Action can imply state obligations to offer protection against third parties, for example protection against (domestic) violence or against environmental pollution. Lastly, there are active or positive duties to fulfil the right, which include duties to establish a justice system and to provide

As mentioned above, human rights imply both ethical and legal demands. As legally binding norms, human rights imply undertakings by government to realize the rights, and as such they fulfil a steering role for protecting a set of values that are based on notions of human dignity and social justice. Subsequently, if states fail to realize rights adequately, they generate state accountability for the values they protect. For

schooling and health care. Altogether, states must adopt legislation and take other measures to respect, protect and fulfil the rights set forth in the treaties that they have adopted.

In principle, human rights are granted to everyone, regardless of civil status, sex, age, race or any other factor. In addition to human dignity, two key notions underlying all human rights are the principles of equality and non-discrimination. Human rights law proscribes all forms of discrimination in access to health care and underlying determinants to health. It identifies a wide number of prohibited discrimination grounds, varying from race, sex, religion, political or other opinion, to physical or mental disability and health status (37). It means that, even in times of resource constraints, the vulnerable members of society must be protected by adopting relatively low-cost targeted programmes (39).

Human rights primarily apply nationally, within a state's national borders. However, states may also have some external or international human rights responsibilities, as members of the international community, and importantly as donors. This study is confined to analysing the human rights responsibilities of European states on their territory; in other words, based on human rights law, what should European states do on their territory to enhance social determinants of health?

Steering role and accountability

example, the arbitrary killing of a suspect by state authorities leads to a violation under the right to life under the international human rights treaties, for which the state authorities can then be held accountable. And likewise, the denial of access to health-care services to a marginalized population group can lead to a violation under the right to health and could be addressed in a case at the national and/or international level.

3.3 Health and human rights: a general introduction

Health and human rights

As mentioned, the core principle underlying human rights law is human dignity. Since health is such an important condition for leading a dignified life (see Chapter 2),

many human rights are connected directly or indirectly to the notions of good health and dignity. These include the right to life, the right to health and the right to privacy,

as well as economic and social rights such as the rights to housing, food and education. The health and human rights framework addresses the interface between health and all of these human rights. Health and human rights is an emergent area under law, public health and other disciplines (40). The central idea of the health and human rights paradigm is that an effective public health policy will promote human rights and that promoting human rights will improve public health.

At the core of the area of health and human rights lies the internationally and regionally recognized right to the highest attainable standard of health (right to health), which

will be discussed below. A range of other rights connect with and reinforce the right to health, including the right to life, the right to privacy, the right to information, and also the rights to food, education and housing (Table 2). As such, both civil and political rights (life, privacy and information) and economic, social and cultural rights (health, food, education and housing) are at stake when it comes to health. This underlines the mentioned notion of the interdependence of human rights, meaning that all rights are interconnected and that they reinforce each other (38).

Recognition of the right to the highest attainable standard of health under international human rights law

Our human rights analysis in a European setting focuses first on the United Nations framework. This framework contains clear definitions of the right to health and of other rights that are important for protecting health. These rights result in binding implications for European countries that have widely ratified the United Nations treaties. In addition, we focus on the European human rights treaties (mainly from the Council of Europe).

We should stress at the outset that many human rights, and also many rights in conjunction with each other, have an importance to health and the social determinants of health. For example, denial of access to a health-related services could be addressed from the angle of the right to health but also, for example, from the perspective of the right to life, the principle of non-discrimination, the right to privacy and family life and the right to social security. So although issues of social justice can be addressed from many human rights angles, in this report we have chosen to take as a starting-point the internationally guaranteed right to health, as it has the most elaborate framework for defining access to health-related services.

The right to health is also a core objective of WHO. In fact, the WHO was the first organization to define health as a right. The preamble to the WHO Constitution (1946) gives a definition of health: “health is a state of complete physical, mental and social well-

being and not merely the absence of disease”. This absolute and broad definition of health is forward-looking in the sense that it not only includes physical but also mental and social well-being. The preamble also recognizes the highest attainable standard of health as a right of every human being. In relation to this, it refers to the relation between health problems and unequal development in different countries, to the importance of the healthy development of the child and to the importance of the informed opinion and active cooperation on the part of the public (41).

WHO’s definition of the right to health was a breakthrough in the field of international health and human rights law. It created an important point of departure for the further elaboration of a right to health in human rights documents, in particular Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights. Article 12 of the International Covenant on Economic and Social and Cultural Rights contains a provision along the lines of the WHO Constitution. This provision is broader than the previously adopted Article 25 of the Universal Declaration of Human Rights, which embeds a right to health in a broader provision on a right to an adequate standard of living. Article 12 of the International Covenant on Economic and Social and Cultural Rights takes a broad approach to health, based on the notion that health is not

merely the absence of disease. Although the concept of social well-being has been deleted, the steps mentioned in the article reflect the interpretation of health as a broad concept, in referring also to environmental hygiene, preventive health care and occupational diseases (42).

The right to health was also recognized in Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979) and Article 24 of the United Nations Convention on the Rights of the Child (1989). While Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women focuses primarily on access to health care for women, Article 24 of the United Nations Convention on the Rights of the Child covers the broader right to health of children to not only health care facilities, but also to adequate food, drinking-water and prohibition of harmful traditional practices. As a result, whereas Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women is aimed at providing women with additional protection where this is needed, Article 24 of the United Nations Convention on the Rights of the Child purports to restate the principles of the WHO Constitution and of Article 12 of

the International Covenant on Economic and Social and Cultural Rights with respect to children.

In addition to the above-mentioned provisions, several other United Nations treaties and declarations refer to the right to health. For example, the Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990) emphasizes equal access to medical care for migrant workers. Article 5(e)(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (1965) is slightly more elaborate, in that it provides in general terms that state parties are to prohibit and eliminate racial discrimination in the enjoyment of public health, medical care, social security and social services. Further, the conventions of the ILO contain numerous references to occupational health. More specifically, Article 25 of ILO Convention No. 169 (1989) explicitly recognizes a right to health of indigenous and tribal peoples. Lastly, the Convention on the Rights of Persons with Disabilities, which was adopted in 2006, contains several references to the health of people with disabilities, including Article 25 on the right to health of people with disabilities.

European health and human rights law

In addition to these global provisions, several European human rights instruments set forth the right to health. The well known and well established European Convention on Human Rights and Fundamental Freedoms contains civil and political rights only. As a result, the right to health cannot be addressed before the European Court of Human Rights in Strasbourg. Nevertheless, this Court increasingly deals with health-related matters such as environmental pollution and the question of whether a denial of access to health care can affect people's right to life (43). Further, Protocol 1 to the European Convention on Human Rights and Fundamental Freedoms sets forth the right to education, which is an important condition for health.

The European Social Charter, adopted in 1965, contains a right to protection of health in Article 11. Article 11 of the

European Social Charter defines three general state undertakings and seeks to bring the responsibility of governments into perspective by referring to the individual responsibility in matters of health and to cooperation with public and private organizations. As such, this provision recognizes the shared responsibility for fulfilling human rights. The text does not refer to children's health and environmental health, yet these matters are raised on an ongoing basis within the framework of the reporting procedure. In 1966, a revised text of the European Social Charter was adopted (the Revised European Social Charter). Apart from a reference to preventing accidents in paragraph 3, Article 11 of the European Social Charter was left unchanged. The Revised European Social Charter recognizes several other health-related rights, the most important of which are Article 3 (safety at work); 12

(social security); 13 (social and medical assistance); 7 and 17 (protection of mothers and children); 19 (protection and assistance to migrant workers and their families); and 23 (social protection of elderly persons).

The Charter of Fundamental Rights of the European Union (2000) contains a provision on health promotion and health care in Article 35. It recognizes the right of access to preventive health care and the right to benefit from medical treatment, albeit under the conditions established by national laws and practices. It binds the EU bodies and Member States when acting within the realm of EU law, but at this time it is uncertain what the

scope and implications of this provision will be (44).

Finally, several national constitutions in Europe contain a right to health. Altogether in Europe, there is strong recognition of the right to health, based on the wide ratification of the relevant United Nations and European treaties as well as the adoption of national constitutional provisions. Based on such provisions, the right to health is generally considered as a broad right, thus recognizing that health is not only realized by providing health care but also through guaranteeing social conditions for health.

Other health-related rights

As mentioned above, the right to health does not stand alone but is reinforced and supported by several other rights. General Comment 14 (paragraph 3) affirms that:

... the right to health is closely related to and dependent upon the realization of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.

These and other rights and freedoms address integral components of the right to health. Some of the most prominent rights linked to health are the rights to life, an

adequate standard of living, information and participation, social security, food, housing, property, education, and employment. Such rights imply legal obligations to ensure access to, inter alia, health-related information, proper food, housing and education. In conjunction with the right to health, these rights have the potential to address people's poor housing conditions, their lack of access to proper education and information and the state of their neighbourhoods and workplaces. Although it goes beyond the scope of this study to give an exhaustive list of all the rights that are potentially relevant to the social determinants of health, Table 2 gives an overview of several of the most important rights.

Table 2. Most important human rights relevant for enhancing the social determinants of health

Human right	United Nations provisions	European provisions
Life	3 Universal Declaration of Human Rights 6 International Covenant on Civil and Political Rights 9 Migrant Workers Convention 10 Convention on the Rights of Persons with Disabilities	2 European Convention on Human Rights and Fundamental Freedoms
Adequate standard of living	25 Universal Declaration of Human Rights 11 International Covenant on Economic and Social and Cultural Rights 27 United Nations Convention on the Rights of the Child 28 Convention on the Rights of Persons with Disabilities	30 European Social Charter

Human right	United Nations provisions	European provisions
Health	<p>12 International Covenant on Economic and Social and Cultural Rights</p> <p>12 Convention on the Elimination of All Forms of Discrimination against Women</p> <p>24 United Nations Convention on the Rights of the Child</p> <p>5 International Convention on the Elimination of All Forms of Racial Discrimination</p> <p>28, 43, 45 Migrant Workers Convention</p> <p>24 Convention relating to the Status of Refugees</p> <p>25 ILO Convention 169</p> <p>25 Convention on the Rights of Persons with Disabilities</p>	<p>2 and 8 European Convention on Human Rights and Fundamental Freedoms</p> <p>11 and 13 European Social Charter</p> <p>35 Charter of Fundamental Rights of the European Union</p>
Information and participation	<p>19 Universal Declaration of Human Rights</p> <p>19 International Covenant on Civil and Political Rights</p> <p>13 and 17 United Nations Convention on the Rights of the Child</p> <p>13 Migrant Workers Convention</p>	<p>10 European Convention on Human Rights and Fundamental Freedoms</p>
Non-discrimination	<p>6 Universal Declaration of Human Rights</p> <p>2-1 International Covenant on Civil and Political Rights</p> <p>2-2 International Covenant on Economic and Social and Cultural Rights</p> <p>2-1 United Nations Convention on the Rights of the Child (see also under health)</p>	<p>14 European Convention on Human Rights and Fundamental Freedoms</p> <p>E European Social Charter</p> <p>21 Charter of Fundamental Rights of the European Union</p>
Social security	<p>9 International Covenant on Economic and Social and Cultural Rights</p> <p>13 Convention on the Elimination of All Forms of Discrimination against Women</p> <p>26 United Nations Convention on the Rights of the Child</p> <p>24 Convention relating to the Status of Refugees</p> <p>27 Migrant Workers Convention</p>	<p>12, 14, 16 and 23 European Social Charter</p>

Human right	United Nations provisions	European provisions
Food	11 International Covenant on Economic and Social and Cultural Rights	11 European Social Charter (not explicitly)
Housing	11 International Covenant on Economic and Social and Cultural Rights 21 Convention relating to the Status of Refugees	31 European Social Charter
Education	13 International Covenant on Economic and Social and Cultural Rights 10 Convention on the Elimination of All Forms of Discrimination against Women 28 and 29 United Nations Convention on the Rights of the Child 30, 43 and 45 Migrant Workers Convention 24 Convention on the Rights of Persons with Disabilities	Protocol 1 to the European Convention on Human Rights and Fundamental Freedoms (as amended by Protocol 11)
Employment	6 and 7 International Covenant on Economic and Social and Cultural Rights 11 Convention on the Elimination of All Forms of Discrimination against Women 17 and 18 Convention relating to the Status of Refugees 27 Convention on the Rights of Persons with Disabilities ILO conventions 25, 38 71 Migrant Workers Convention	1–4, 7–10, 18–22 and 24–29 European Social Charter

In the literature, the links between the right to health and the other rights have been established on many occasions (42). For example, Braveman emphasizes the connections between the rights to a standard of living and education on the one hand and the right to health on the other (45). Braveman stresses that access to general schooling is a crucial social determinant of

health. In accordance with Amartya Sen's capability approach (Chapter 2), education can be seen as a fundamental element in enhancing the capability to be healthy. Along similar lines, Article 13(1) of the International Covenant on Economic and Social and Cultural Rights affirms that education shall "enable all persons to participate effectively in society".

3.4 The conceptual link between human rights and the social determinants of health inequalities

This section analyses the scope of the right to health and addresses the question of whether it can serve as a framework to address the social determinants of health. As mentioned, an important landmark for defining the right to health was the adoption in 2000 of General Comment No. 14 discussing the right to the highest attainable standard of health in Article 12 of the International Covenant on Economic and Social and Cultural Rights. General comments are documents adopted by United Nations treaty-monitoring bodies with the aim of explaining the meaning and implications of a certain aspect of the treaty concerned to assist states parties in fulfilling their reporting obligations. The General Comment on the Right to Health was adopted by the Committee on Economic, Social and Cultural Rights after consultation with NGOs and WHO. The document reflects the debate about the right to health that took place in the years leading up to the adoption of this text. As this document gives the most authoritative and most comprehensive analysis of the right to health, we use this document as an important frame of reference in relation to our human rights analysis of social determinants of health. Although the document is not legally binding (and as such is a soft-law instrument), it has by now obtained considerable moral and legal weight.

The General Comment takes a broad approach to defining health as a human right. In paragraph 4, it recognizes that the broad scope of the right to health:

... “the highest attainable standard of physical and mental health” is not confined to the right to health care. On the contrary, the drafting

history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

The European Social Charter also interprets the right to health in this broad fashion. According to the Secretariat of the European Social Charter, Article 11 covers numerous issues relating to public health, such as food safety, protection of the environment, vaccination programmes and alcoholism.

A key question is whether this broad underpinning of the right to health, in conjunction with the other health-related rights, has the potential to offer a framework for addressing social determinants of health. Hunt asserts that there are multiple, dense connections between social determinants and human rights (9). He states that:

There is considerable congruity between the Commission’s mandate and the “underlying determinants of health” dimension of the right to health, as well as other interconnected human rights such as adequate housing, food and water. In other words, national and international human rights law informs and reinforces the Commission’s mandate.

Hence we need to find out more precisely whether the mentioned underlying determinants of health under the right to health in conjunction with the other health-related rights are congruent with social determinants of health, as outlined in the report of the Commission on Social Determinants of Health.

3.5 Analysing the framework of the right to health and the other health-related rights

As was mentioned above, General Comment 14 provides a strong and well developed normative framework for analysing the right

to health. Seven elements of this document can be used as a framework for addressing social determinants of health.

Availability, accessibility, acceptability and quality

In Paragraph 12, the General Comment enumerates a set of principles that relate to the provision of health-related services.

Similar principles are stated in the General Comments on the right to food, housing, and education. This set of principles is availability,

accessibility, acceptability and quality. Accessibility has four overlapping dimensions: non-discrimination, physical accessibility,

economic accessibility and information accessibility (Table 3).

Table 3. Availability, accessibility, acceptability and quality – guiding principles for the right to health from General Comment 14

Availability	Functioning public health and health-care facilities, goods and services, as well as programmes, are available in sufficient quantity within the state party.
Accessibility	Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the state party.
<i>Non-discrimination</i>	Health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds.
<i>Physical accessibility</i>	Health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older people, people with disabilities and people living with HIV.
<i>Affordability</i>	Health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups.
<i>Information accessibility</i>	The right to seek, receive and impart information and ideas concerning health issues.
Acceptability	All health facilities, goods and services are respectful of medical ethics and culturally appropriate, that is, respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned.
Quality	Health facilities, goods and services are scientifically and medically appropriate and of good quality.

Although this set of principles seems very much directed at health-care settings, we may presume that the availability, accessibility, acceptability and quality or a set of similar principles relates very much to all the determinants of health and that all services related to the determinants of health should meet such conditions. First, the General Comment explicitly states that these principles also address the determinants of health (Paragraph 12). This means, for example, that health-related information will have to be provided based on the principle of non-discrimination, while occupational health facilities must be accessible and affordable to everyone. A second reason to presume that these principles relate to all the determinants of health is because these principles are

common to many of the other general comments. For example, education has to be available, accessible, acceptable and adaptable. Altogether, we observe that the arguments about extending the availability, accessibility, acceptability and quality beyond the provision of health-care services could be developed further. Here are some examples of how this framework can be applied when addressing social determinants of health.

- In middle-income country X, occupational health facilities are poor in a certain region and are affecting workers, especially migrant workers. In international human rights terms, this means that occupational health facilities are insufficiently available and accessible, and of insufficient quality, guiding principles under the right to health.

- In high-income country Y, school canteens across the country provide only unhealthy food and they sell soft drinks. The authorities of Y fail to ensure that good-quality food is available and accessible, guiding principles under the rights to health and food.
- In middle-income country Z, housing conditions in several areas of the capital are poor and have damaging health effects. The authorities of Z fail to meet the conditions of availability, accessibility and quality under the rights to health and housing.

Accountability and participation

Further, it is increasingly recognized that the principles of accountability and participation are important conditions underlying the right to health (Table 4). Although the right to health provisions do not explicitly mention the notion of accountability, it is increasingly regarded as an essential component of the right to health. General Comment 14 on the Right to the Highest Attainable Standard of Health refers to accountability in the following way (Paragraphs 55 and 59).

The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realization of the right to health.

Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition. National ombudsmen, human rights commissions, consumer forums, patients' rights associations or similar institutions should address violations of the right to health.

The principle of participation, second, is essential for giving the population as a whole as well as vulnerable population groups a voice to address their specific health vulnerabilities. General Comment 14 recognizes that (Paragraph 17):

A further important aspect [of Article 12-2-d of the International Covenant on Economic and Social and Cultural Rights] is the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organization of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.

The Commission on Social Determinants of Health acknowledged political participation as one of the important tools for addressing social determinants of health. Potts gives various interesting examples of how the public can have say in important decisions in the health decision-making process: regional and national conferences, permanent or time-bound forums, local health committees or teams, focus groups and individual interviews, citizens' juries or planning cells, public meetings, budgetary oversight and local committee selections (46). Potts stresses that an important purpose of participation in the context of the right to health is to recognize and respect difference and diversity within the population and to ensure inclusiveness in developing health policy (46). This is also important in the context of health inequalities: a participatory decision-making process can bring the different health inequalities and the underlying causes to the table.

Table 4. Accountability and participation as important additional principles in the right to health framework

Accountability	Adopting a broad set of mechanisms (including monitoring mechanisms) for holding all the actors in the health sector and connected branches accountable for their actions.
Participation	The active and informed participation of people and groups in the health decision-making process, such as through regional and national conferences, local health committees or teams, public meetings, budgetary oversight and local committee elections.

Source: Potts (46).

Non-discrimination and vulnerable groups

The General Comment pays specific attention to the principle of non-discrimination and the position of vulnerable groups (Paragraph 18, see also General Comment 20).

By virtue of article 2.2 and article 3, the Covenant proscribes any discrimination in access to health care and underlying determinants of health, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.

Further, it emphasizes in Paragraph 19 that states have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities and to prevent any discrimination on internationally prohibited grounds in providing health care and health services. It mentions the following vulnerable groups: women, children and adolescents, older people, people with disabilities and indigenous peoples. It is perhaps somewhat limiting that only some vulnerable groups are mentioned and that the focus is very much on providing health care. But by emphasizing the need to enhance access to health

services for disadvantaged individuals, the General Comment clearly opens the door to addressing health inequalities.

Other human rights treaties pay attention to specific vulnerable groups, such as the Convention on the Elimination of All Forms of Discrimination against Women (women), the United Nations Convention on the Rights of the Child (children), the Convention on the Rights of Persons with Disabilities (people with disabilities) and Migrant Workers Convention (migrant workers). These treaties spell out concrete state obligations in health, education, social security and employment that fall under social determinants of health. However, addressing the needs of vulnerable population groups does not fully cover the broad range of problems that arise under inequalities in health. Inequalities in health are not confined to poor health among the most deprived. The Marmot review (47) refers to this notion as proportionate universalism.

Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

Definition of legal state obligations

Another important concept that is elaborated upon in the General Comment concerns the distinction between three types of state obligations, as was also mentioned above. The General Comment explains that the right to health, like all human rights, imposes three types or levels of obligations on states parties: the obligations to respect, to protect and to fulfil. Although this identification may not always be applicable and useful in a policy-oriented context, it is generally considered to be a useful tool for identifying the legal obligations of states in relation to a right to health (48).

The obligation to respect is a negative state obligation and requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health. When it comes to the underlying determinants of health, this implies a duty on the part

of governments to refrain from denying or limiting equal access to all health-related services as well as abstaining from enforcing discriminatory practices as a state policy in this regard (General Comment 14, Paragraph 34).

The obligation to protect usually involves other non-state actors against which protection needs to be offered by the government. As such, it may include measures that prevent third parties from interfering with Article 12 guarantees. The obligation to protect is important when tackling the role of private industry in relation to the social determinants: there is a clear role for governments to regulate private industry to ensure that they do not market unhealthy products.

Lastly, the obligation to fulfil requires that states adopt appropriate legislative,

administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. This clearly means ensuring not only access to health services but also access to the underlying determinants of health. Reading the right to health in conjunction with the other economic and social rights, it means an

obligation to ensure access to early services and conditions including childhood care, education, housing, employment and a clean environment.

Table 5 outlines some examples of legal obligations that states have under the right to health in conjunction with other rights.

Table 5. Legal state obligations in relation to social determinants of health pursuant to General Comment 14

State obligations to respect economic, social and cultural rights	Refrain from denying or limiting equal access to health-related services Refrain from enforcing discriminatory practices as a state policy
State obligations to protect economic, social and cultural rights	Adopt legislation and other measures to regulate private industry (such as the food and tobacco industries)
State obligations to fulfil economic, social and cultural rights	Ensure equal access to the underlying determinants of health (including nutritiously safe food and adequate housing and living conditions) Ensuring that the social conditions for health form an integrated part of the national health policy

Progressive realization and core obligations

The right to health, like all human rights, is subject to resource availability, meaning that higher-income countries can do more than lower-income countries. The right to health is therefore subject to progressive realization, meaning that governments are required to progressively work towards its realization (Article 2-1 of the International Covenant on Economic and Social and Cultural Rights). States are to take steps “to the maximum of their available resources”. Progressive realization also means that retrogressive measures are not justified (49).

To ensure that there is a bottom line or minimum level of service provision below which no government should fall, the General Comment outlines in Paragraphs 43–44 several core obligations that states have to

ensure under all circumstances. To define these core obligations, the General Comment draws from the Programme of Action of the International Conference on Population and Development (1994) and the primary health care strategy as set forth in the Declaration of Alma-Ata (1978).

Among the core obligations are several services that address the underlying determinants of health (Box 1). This means that irrespective of a state’s available resources, based on the right to health, it has to guarantee minimum essential food, basic shelter and education concerning the main health problems. This shows that some of the underlying determinants of health form part of the minimum core elements of the right to health, as outlined in General Comment 14.

Box 1. Minimum core obligations addressing the social determinants of health pursuant to General Comment 14

Minimum essential food that is nutritionally adequate and safe

Basic shelter, housing and sanitation

Child health care

Education and access to information concerning the main health problems

Indicators and benchmarks

The report of the Commission on Social Determinants of Health stresses the importance of monitoring health equity and its underlying determinants (3). A possible way to monitor the right to health is through the use of indicators and benchmarks, tools that are frequently used within the human rights framework. Indicators are tools to indicate the situation at a point in time, for example the maternal mortality rate. Benchmarks are self-set goals or targets to be achieved at some future date, such as reducing the maternal mortality rate by half in 2020 (50). Fully expressing the human rights perspective in such an assessment requires disaggregating these indicators by sex, urban versus rural and/or socioeconomic or ethnic group or any other category that reveals meaningful inequalities. These indicators could then function as the key indicators to comprise the basis of further developing national benchmarks.

In a report in 2008, the Officer of the High Commissioner for Human Rights of the United Nations distinguishes between structural, process and outcome indicators for each human right (51). It is encouraging to note that a large proportion of the indicators for the right to health focus on the underlying determinants for health: child health and nutrition, breastfeeding, access to safe drinking-water and sanitation, population living near hazardous conditions, road safety, abuse of substances and occupational deaths, injuries and diseases. Nevertheless, several social conditions that are important in Europe, including the lifestyle-related issues, are not mentioned: alcohol abuse, smoking prevalence, food consumption and obesity

Obligations of non-state actors

States, as the actors that have ratified the human rights treaties, bear primary responsibility for international human rights law. In addition to this, it is increasingly argued that non-state actors bear a certain derived responsibility under human rights law (53). To underline this responsibility, reference is often made to the preamble of the Universal Declaration of Human Rights, which refers to the human rights responsibilities of “every individual and every organ of society”. Although states bear

and unhealthy lifestyles more generally. In addition, these indicators recognize the existence of the mentioned causes of the causes of health, such as the structure of society, income inequality and social and cultural norms and values (see below). The indicators developed for the right to food clearly reflect the same broad yet globally oriented approach.

Altogether, the human rights framework lacks a European-specific set of indicators that is sufficiently geared towards tackling social determinants of health in a European setting. Some inspiration for this can be drawn from Fukuda-Parr, who distinguishes between indicators for low- and middle-income countries and indicators for high-income countries in relation to a set of economic and social rights (52). Further, we may draw from the Marmot review (47), which analyses health inequalities in England. This report presents 12 health indicators: (1) death rates from cancer and heart disease; (2) teenage conception rate; (3) road accident casualty rates in disadvantaged communities; (4) numbers of primary care professionals; (5) uptake of flu vaccination; (6) smoking among manual occupation groups and among pregnant women; (7) educational attainment; (8) consumption of fruit and vegetables; (9) proportion of population living in non-decent housing; (10) physical education and school sport; (11) children in poverty; and (12) homeless families living in temporary accommodation. The human rights framework could consider using a similar set of indicators to monitor compliance with the state’s duty to ensure adequate social determinants of health.

primary responsibility for realizing the right to health, fulfilling the right to health requires a multistakeholder approach, in which all actors, including governments, international organizations, professional associations, civil society organizations and the business sector, each play their role. This is also confirmed by General Comment 14 (Paragraph 42).

While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society – individuals, including health professionals, families, local communities, intergovernmental and non-governmental

organizations, as well as the private business sector – have responsibilities regarding the realization of the right to health

This is an important starting-point for further defining the legal or moral obligations of non-state actors in relation to social determinants of health. All non-state actors should be

aware that health inequalities exist and that socioeconomic circumstances need to be tackled. To give one specific example: the business sector plays a particularly important role when it comes to the production and marketing of (un)healthy products, such as the sale of tobacco.

3.6 Linking the rights framework with the goals of the Commission on Social Determinants of Health

The framework of the right to health and the other health-related rights was analysed above, and an attempt was made to discuss how this framework can be used as a tool for holding governments and other actors to account in relation to health inequalities. To

draw some final conclusions on this, a link needs to be established between the goals of the Commission on Social Determinants of Health and the rights framework that was set out above (Table 6).

Table 6. Social determinants and human rights

Goals of the Commission on Social Determinants of Health	Specific goals of the Commission on Social Determinants of Health	Legal state obligation	General Comment 14
1. Child development	<ul style="list-style-type: none"> Access to high-quality early child development programmes Early childhood development High-quality compulsory primary and secondary education Preschool education programmes 	<ul style="list-style-type: none"> 11 International Covenant on Economic and Social and Cultural Rights (food, clothing, housing) 24 United Nations Convention on the Rights of the Child (health) 27 United Nations Convention on the Rights of the Child (standard of living) 28, 29 United Nations Convention on the Rights of the Child (education) Protocol 1 to the European Convention on Human Rights and Fundamental Freedoms (education) 	Paragraphs 14 and 22–24
2. Living environment	<ul style="list-style-type: none"> Availability of affordable housing Investment in urban slum upgrading Promote health equity between rural and urban areas Counter the inequitable consequences of urban growth 	<ul style="list-style-type: none"> 25 Universal Declaration of Human Rights (standard of living) 11 International Covenant on Economic and Social and Cultural Rights 21 Convention relating to the Status of Refugees 	Paragraphs 9, 11, 34, 43–44 and 53–56
3. Employment and decent work	<ul style="list-style-type: none"> Access to full and fair employment and decent work Safe, secure and fairly paid work, year-round work opportunities, and healthy work–life balance Adequate living wage Protection of workers 	<ul style="list-style-type: none"> 6 and 7 International Covenant on Economic and Social and Cultural Rights 11 Convention on the Elimination of All Forms of Discrimination against Women 17 and 18 Convention relating to the Status of Refugees 27 Convention on the Rights of Persons with Disabilities ILO Conventions 25, 38 -71 Migrant Workers Convention 	Paragraphs 4, 15 and 51

Goals of the Commission on Social Determinants of Health	Specific goals of the Commission on Social Determinants of Health	Legal state obligation	General Comment 14
4. Social protection	<p>Universal comprehensive social protection policies that support a level of income sufficient for healthy living for all</p> <p>Social protection for those in precarious work, including informal work and household or care work</p>	<p>9 International Covenant on Economic and Social and Cultural Rights</p> <p>13 Convention on the Elimination of All Forms of Discrimination against Women</p> <p>26 United Nations Convention on the Rights of the Child</p> <p>24 Convention relating to the Status of Refugees</p> <p>27 Migrant Workers Convention</p>	Paragraphs 15 and 51
5. Universal health care	<p>High-quality health-care services with universal coverage, focusing on primary health care</p> <p>Strengthen public leadership in health care</p> <p>Invest in national health workforces</p>	<p>Right to health:</p> <p>12 International Covenant on Economic and Social and Cultural Rights and General Comment 14</p> <p>12 Convention on the Elimination of All Forms of Discrimination against Women</p> <p>24 United Nations Convention on the Rights of the Child</p> <p>5 International Convention on the Elimination of All Forms of Racial Discrimination</p> <p>28, 43, 45 Migrant Workers Convention</p> <p>24 Convention relating to the Status of Refugees</p> <p>25 ILO Convention 169</p> <p>25 Convention on the Rights of Persons with Disabilities</p>	Paragraphs 12, 16–17 and 43
6. Health equity in all policies	<p>Establishing health equity as a marker of government performance</p> <p>Impact assessments of health and health equity</p> <p>Adoption of a social determinants framework and building supports and structures to encourage this</p>	See above, “right to health”	Paragraphs 12, 16, 18–27, 34 and 36
7. Fair financing	<p>Fairly allocate government resources for action on the social determinants of health</p> <p>Establish mechanisms to fund cross-government action on social determinants of health and to allocate money fairly between geographical regions and social groups</p>	<p>12 International Covenant on Economic and Social and Cultural Rights</p> <p>2-1 International Covenant on Economic and Social and Cultural Rights (“progressive realization” “to the maximum of a State’s available resources”)</p>	Paragraphs 52 and 53

Goals of the Commission on Social Determinants of Health	Specific goals of the Commission on Social Determinants of Health	Legal state obligation	General Comment 14
8. Market responsibility	<p>Reinforce the primary role of the state in providing basic services essential to health</p> <p>Regulation of goods and services with a major impact on health</p>	<p>12 International Covenant on Economic and Social and Cultural Rights</p> <p>("obligation to protect" of governments)</p>	<p>Paragraphs 43–45 and 63–65</p>
9. Gender equity	<p>Address gender biases in the structures of society</p> <p>Adopt legislation that promotes gender equity</p> <p>Develop and fund policies and programmes that close gaps in education and skills and that support female economic participation</p> <p>Increase investment in sexual and reproductive health services</p>	<p>1–5 and 7–16 Convention on the Elimination of All Forms of Discrimination against Women</p>	<p>Paragraphs 10, 16, 20–21, 35 and 52</p>
10. Political empowerment	<p>Empowerment of groups in decision-making about how society operates</p> <p>Create a role for civil society</p>		<p>Paragraphs 11 and 54–55 and 59–62</p>
11. Good global governance	<p>Make health equity a global development goal</p>	<p>2-1 International Covenant on Economic and Social and Cultural Rights: international assistance and cooperation</p>	<p>Paragraphs 38–42 and 63–65</p>
12. Knowledge, monitoring and skills	<p>Availability of monitoring systems for health equity</p> <p>Investment in generating and sharing evidence on social determinants of health</p> <p>Training on the social determinants of health</p>	<p>12 International Covenant on Economic and Social and Cultural Rights (health-related information)</p>	<p>Paragraph 56</p>

The second column outlines the specific goals Commission on Social Determinants of Health that are defined to achieve in order to tackle health inequalities. The third and fourth columns mention the specific human rights provisions on which these goals can be based. Whereas the third column mentions the legal state obligations based on international human rights law, the fourth column refers to the relevant paragraphs of General Comment 14. Based on these links, we can reinforce the claims under the Commission on Social Determinants of Health with reference to the mentioned human rights norms. For example, we can affirm the state's duty to offer social protection with reference to the legal rights under Article 9 of the International Covenant on Economic and Social and Cultural Rights (right to social security) and the other mentioned norms.

A further exercise is needed to more precisely link the legal state obligations to the goals of the Commission on Social Determinants of Health and to find out whether they are fully covered by the legal obligations. It will emerge that many goals are fully covered by the legal obligations (such as primary and secondary education and high-quality health-care services) and that some other aspects are not fully covered (such as cross-government action on the social determinants of health and investments in generating and sharing evidence on social determinants of health).

Here it is important to note that, although the underlying determinants of health cover many of the issues mentioned in the report of the Commission on Social Determinants of Health, some further sophistication of

the underlying determinants is needed to equip this framework fully for this task. The human rights framework needs to be inspired and fortified by the public health and epidemiological frameworks, which provide evidence of more thorough understanding of what causes health. More specifically, it does not fully recognize that health is also determined by societal structures and how people are raised and relate to one another. In a similar vein, Chapman argues that the human rights approach insufficiently considers the role of determinants as factors that determine the health status and outcomes of individuals and communities (54). The human rights community needs to pay greater attention to how people's living conditions shape health and well-being.

To start with, a process of awareness-raising among the human rights community is required to embed this approach more fully into the human rights framework. To give an example: say that a human rights NGO wants to address the poor health of immigrant children in a deprived area of a large city. Important causes of their poor health may be the unavailability of affordable and accessible health care services as well as the diet and lifestyles of these children. However, other more remote causes of the poor diet, lifestyle and health of these children may be the quality of their schooling, housing conditions, the social position of their parents and the level of social cohesion in the neighbourhood. By being informed about the existence of such causes of the causes, the NGO concerned can more effectively address the health problems of these children and base its arguments on human rights law.

3.7 Conclusions and challenges

1. Throughout Europe, health inequalities are substantial, with differences in life expectancy up to 10 years or more between people with higher and lower educational, occupational or income levels. Therefore, one of the major health challenges facing Europe today concerns addressing the increasing health inequalities in a time of decreasing economic resources.
2. As argued in Chapter 2, health inequalities are matters of social justice. From Chapter 3, we conclude that the human rights framework is a good tool for addressing these inequalities and the underlying social determinants. With its emphasis on legal obligations, the position of vulnerable groups and notions including participation and accountability, the human rights framework reinforces and strengthens the notion that health

- inequalities and the underlying social determinants are matters of social justice.
3. The right to the highest attainable standard of health is the key right in this analysis. The right to health is connected to many other human rights, and together they offer a framework for addressing the broad range of social determinants of health (Table 6). These include civil and political rights as well as economic, social and cultural rights.
 4. The right to health means not only accessing health-care services but also about realizing the underlying determinants of health. To a certain extent, these underlying determinants can be addressed by using other human rights (such as rights to housing, food, social security and education), but the notion of the causes of the causes is still broader and more sophisticated, and the human rights framework must in this respect draw inspiration from the public health framework.
 5. An essential component of this process should be adjusting the existing human rights indicators for health. To better address the social determinants of the health-related rights in Europe, a broad set of indicators should be developed, based on a number of interconnected rights, addressing health in conjunction with education, food, housing and social security and taking into account other relevant factors of contemporary European societies. It was suggested that, for this, inspiration can be drawn from indicators from the framework of the public health community (Marmot review).
 6. This report has presented a few central tools in the human rights framework. A key notion concerns the definition of a set of guiding policy principles (availability, accessibility, acceptability and quality) for the right to health. Hence, services necessary to realize health equity have to be available, accessible, acceptable and of good quality. Accessibility of such services means that the services are provided on a non-discriminatory basis, that they are affordable, geographically accessible and that sufficient information is provided in relation to the service concerned.
 7. Two additional crucial notions are accountability and participation. Human rights law offers a legally binding framework for holding governments accountable for realizing human rights before both national and international judicial and quasi-judicial bodies. In addition, there are other forms of accountability, including the steering role that human rights can play in drafting new laws and policies and the political role they can play in NGO activities.
 8. Further, paying attention to vulnerable groups in a human rights perspective is important. However, paying attention to vulnerable groups only does not recognize the notion of the social gradient in health. In addressing the social determinants of health, we must not solely focus on specific vulnerable groups but also address the population at large.
 9. There are certain minimum core obligations inherent in the right to health that apply under all circumstances, which touch upon social determinants of health. Further, based on human rights law, the underlying determinants have to be realized progressively, and retrogressive measures are not allowed.
 10. Like any other framework, the human rights framework has its limitations. But if we recognize such limitations and explore all the possible options for its improvement, human rights have the potential to play an important role in advancing social action on health equity. A concerted effort by both human rights and public health specialists could further equip the human rights framework for addressing the vital conditions for health.

4. Implementation of a human rights approach in the context of health inequalities: 15 case studies

4.1 Introduction

The previous chapter analysed the normative human rights framework in relation to the framework of social determinants of health. The next step is to focus on implementing the human rights framework in this context. The aim is to assess the actual possibilities the human rights approach offers to address harmful social determinants of health and to tackle health inequalities.

Various perspectives can be useful in implementing the human rights framework. A first perspective is upholding rights in adopting new laws and policies by governments. Subsequently, if governments fail to realize these obligations, human rights law offers a legally binding framework for holding governments accountable for human rights violations before both national and international judicial and quasi-judicial bodies. This section specifically focuses on the second perspective. More specifically, we look at existing cases of human right violations in which human rights have been applied. By looking at specific cases, we hope to learn more about how we can use the human rights framework effectively in addressing social determinants of health. In this sense, the proof of the pudding is in the eating.

To find suitable cases, we conducted an Internet and database search, surveyed the websites of human rights organizations and contacted about 30 key informants (see acknowledgements). Based on this search, we collected 25 cases. Of these, we selected 15, mostly from the WHO European Region, that we considered to be useful for obtaining better understanding of the practical use of the human rights framework within the context of health inequalities. These cases do not necessarily deal with health, but might also deal with the underlying social determinants (such as access to social security as a determinant of health).

The analysis of the cases that follows is largely exploratory and descriptive. The 15 cases are described in terms of the problem that was central to the case, the human rights law that was used to hold the government to account for this problem and the extent to which this claim has been successful. We do this for different forms of accountability (sections 4.3–4.7). In the discussion section (4.8), we evaluate how effective human rights law was in addressing the social determinants of health in the case studies.

4.2 Accountability mechanisms and case studies

As discussed in the previous chapter, states have legal duties to respect, protect and fulfil the health-related rights. An important aspect of the duty to protect rights is the state's duty to set up mechanisms to demonstrate and justify how it has discharged its obligations regarding the rights concerned (46). This

process is usually called accountability. Potts states that an effective accountability process comprises the following elements: monitoring, accountability mechanisms, remedies and participation. Monitoring means consistently analysing and overseeing the process towards the realization of rights.

Accountability mechanisms ensure that the state is held to account for a failure to realize the rights. Remedies are means of redress when rights have been violated and can roughly speaking appear in three forms: restitution, compensation or rehabilitation. An important element in this entire process is the participation of the public in the decision-making process over issues that involve their rights.

Although the accountability process includes monitoring and evaluating the state's own actions, the responsibilities are partly in the hands of other actors. Other actors can include private health-care providers and insurance companies. Private actors may also influence health through their actions. We can especially identify tobacco and food companies, as well as pharmaceutical companies, but also for example industries that have a potential negative impact on the (environmental) health of surrounding communities. In such cases, the state has a duty to oversee the actions of these private actors by moderating the actions of the private actors. It is important to note here that the state bears the ultimate responsibility for realizing the health-related rights and can never be discharged from this responsibility by arguing that a private actor has taken over

the responsibility (55). Altogether, although we recognize the responsibilities of non-state actors, we mainly focus on the actions and responsibilities of states, including their duty to moderate these non-state actors.

We focus primarily on accountability mechanisms and on how they are used by the state (and other actors) to ensure the realization of the health-related rights. In other words, we look at cases in which accountability mechanisms were used in addressing social determinants of health. Although the focus is on accountability mechanisms, the elements of monitoring and remedies will to some extent implicitly come to the fore. Monitoring, for example, is an element of human rights impact assessment, and remedies are at stake in the judicial case studies we discuss. Lastly, as mentioned above, the notion of participation is considered an important element in the accountability process.

Accountability for human rights violations is not only about judicial accountability or "naming and shaming" (9,55); it can appear in several other forms. Table 7 gives an overview of the five forms of accountability identified along with their respective national and international mechanisms.

Table 7. Five types of national and international accountability mechanisms

Type of accountability	Mechanisms
Judicial	National judicial review, constitutional redress, public interest litigation International courts
Quasi-judicial	National human rights institutions, national ombudspersons Regional and international human rights treaty bodies
Administrative	Human rights impact assessment International human rights impact assessment
Political	Parliamentary committees United Nations and regional human rights bodies
Social	National NGOs, the mass media International NGOs

Case studies

We have selected case studies based on the following criteria.

- They address one or more social determinants of health, including housing conditions, schooling, environmental health, occupational health and access to social and health services.
- They were based on human rights: we have searched for cases in which the human rights framework was explicitly used as a framework for the case at issue.
- They were mostly based in various countries in the WHO European Region, although two cases are from outside the Region.
- They generated state accountability (in different forms) for the social determinants of health under human rights law.
- Ideally, they positively influenced the people affected by the case. This type of impact is what Gloppen calls “success in the material sense” (56). Generating accountability is no guarantee that of actual impact on the people affected. Our search was not restricted to cases in

which there was a measurable positive output for individuals or groups; rather, we searched for cases in which accountability was generated, while a successful, desired outcome (such as policy change) was seen as an added value.

- Further, ideally the cases under scrutiny affect a population group as such or the wider population, implying a collective right to health. In other words, our ultimate aim is to find out how such precedents can reduce health inequalities. This is what Gloppen calls “success in the social sense” or “social outcome” (56). It largely goes beyond the scope of this study, however, to verify and measure whether the case studies under scrutiny had direct and measurable impact. We will discuss this issue in the conclusion of this chapter.

For each form of accountability at the national level (Table 8) and international level (Table 9), we provide one or more case studies, and we mention the country in which the particular case occurred as well as the main topic that was addressed in the case.

Table 8. Overview of national accountability and the included case studies

Type of accountability	Mechanisms	Country	Description
Judicial	Birmingham City Council	England	Social and care for people with disabilities
	Fischer Advocaten	Netherlands	Access to social and health care for undocumented migrants
	Latvian Constitutional Court	Latvia	Access to social insurance premiums
Quasi-judicial	The Human Rights Ombudsman	Slovenia	Inter alia, regional difference in education
Administrative	Aberdeen City Council	Scotland	Human rights and equality assessment of policies
Political	Senate’s Subcommittee on Population Health	Canada	Report on social determinants of health
	Joint Committee on Human Rights	England	Victimization and neglect of older people
Social	I Can Live Coalition	Lithuania	Treatment and care for people who inject drugs
	PPR/Seven Towers Project	Northern Ireland	Inter alia, housing conditions

Table 8. Overview of national accountability and the included case studies

Type of accountability	Mechanisms	Country	Description
Judicial	European Court of Human Rights	European-wide	Inter alia, case law on health risks, including environmental pollution
Quasi-judicial	European Committee of Social Rights	European-wide	Inter alia, case law on living conditions and housing
Administrative	Aim for Human Rights/ Rights4Change	Netherlands	Using the Health Rights of Women Assessment Instrument
Political	United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health	Sweden	Access to health care for undocumented migrants
	United Nations General Assembly	Worldwide	High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases
Social	Centre for Economic and Social Rights and Observatory of Economic, Social and Cultural Rights (Observatorio DESC)	Spain	Effects of austerity measures

4.3 Judicial accountability

Judicial or legal accountability refers to holding the state accountable through international and national court cases before judicial bodies. Judicial bodies can be described as independent and impartial bodies competent to give legally binding judgements based on the facts determined by due process.

When it comes to legal accountability, international and domestic courts worldwide have increasingly enforced access to health-related services (49). However, most of the examples of enforceability of the right to health materialized in the global South, where dramatic cases have been addressed before the courts (49). Due to the absence

of social security nets, the violations of the rights are clear and persistent. In high-income countries, where the debate is much more about the sufficiency of the benefit level, there is less urgency to seek enforcement or justiciability of economic and social rights, including the rights to health, education and employment. As such, enforcing economic, social and cultural rights before a court of law is problematic, especially in Europe. The right to health framework has been applied only to a limited extent in Europe before national courts and the European institutions, as there is reluctance to seek the enforcement of human rights and economic, social and cultural rights in particular.

Case study 1 Birmingham City Council, England, United Kingdom

The families of four severely disabled adult residents of Birmingham, who were the recipients of adult social care services, brought a case against Birmingham City Council (the Council). They argued that the proposed policy change in social care for

people with disabilities was unlawful and that it could lead to unmet needs of many people with disabilities, since alternative resources were lacking in the community. Further, it could increase the burden on them disproportionately, thereby possibly

jeopardizing adequate care and risking the lives of people with disabilities.

Before the Court, the claimants argued that the change was unlawful, as it failed to pay due regard to the disability equality duty according to the Disability Discrimination Act 1995. They added that this new policy failed to observe Article 8 of the European Convention on Human Rights and Fundamental Freedoms. The Court concluded that the Council had insufficiently assessed the practical impact of this change on people with disabilities with “substantial” needs and that it, as a result, did not pay due regard to the disability equality duties. The Court also declared that both the decision-making and the consultation process leading up to this change were inadequate. However, the Court did not use the rights in the European Convention on Human Rights and Fundamental Freedoms in the decision, arguing that the rights in the European Convention on Human Rights

and Fundamental Freedoms did not add in substance to the challenge already advanced.

In this case study, the claimants initially used the human rights framework (European Convention on Human Rights and Fundamental Freedoms) to improve daily living conditions and ensure social protection for a number of persons with disabilities. Although the domestic Court did not take the rights in the European Convention on Human Rights and Fundamental Freedoms into consideration in its final assessment, the European Convention on Human Rights and Fundamental Freedoms surely provides a framework to be used in such cases in the future. As case study 4 illustrates, the European Court of Human Rights increasingly applies to the civil and political rights in the European Convention on Human Rights and Fundamental Freedoms in relation to the social determinants of health. A similar trend may occur at a domestic level.

Case study 2

Fischer Advocaten, Netherlands

Fischer Advocaten (Haarlem, Netherlands) is a law firm that specializes in providing legal aid to people living below the poverty level and who are deprived of social support despite being entitled to such services.¹ This may concern the withdrawal of social services, social or health care, the refusal to provide shelter to homeless people but also the detention of adolescents without appropriate treatment and support. The law firm bases its claims on human rights as laid down in various international human rights treaties. Regarding the rights used for their complaints, Pim Fischer states the following:

The treaties that we use most frequently are the European Convention on Human Rights and Fundamental Freedoms and the United Nations Convention on the Rights of the Child. In addition, the European Social Charter is used for the interpretation of the duties resulting from Article 8 of the European Convention on Human Rights and Fundamental Freedoms (right to privacy and family life). The Decision of the

European Committee of Social Rights in *DCI v. the Netherlands* has facilitated this application.²

It is interesting to observe how in this case a decision of an international body (*DCI v. the Netherlands* of the European Committee of Social Rights) has generated legal accountability at a domestic level.

In the list of cases that this law firm has addressed, there is a particular emphasis on people who do not have a residence permit. For example, one of their recent cases concerned the withdrawal of health care from a Somalian man illegally residing in the Netherlands. This person had severe mental health problems, was unable to look after himself and posed a risk to himself and to individuals in his environment.³ The complaint led to a decision of the Dutch Central Appeals Court that the withdrawal of health care to a “vulnerable” person illegally residing in the Netherlands violated the right

¹ <http://www.fischeradvocaten.nl/index.php?&w=88>, accessed 22 October 2015.

² Pim Fischer, Fischer Advocaten, see www.fischeradvocaten.nl, accessed 22 October 2015. *DCI v. the Netherlands*: see below in the section on legal accountability.

³ Decision of September 2011, <http://www.fischeradvocaten.nl/index.php?&w=71>, accessed 22 October 2015.

to privacy and family life in Article 8 of the European Convention on Human Rights and Fundamental Freedoms (right to privacy and family life). According to the Court, given his vulnerability, the health authorities were positively obligated to provide him the necessary services.⁴ In similar cases, Fischer Advocaten has addressed the lack of social benefits, child benefits, housing facilities and access to education, especially for undocumented migrants.

The practice of this law firm demonstrates how legal action at a domestic level can

address the living conditions of the most vulnerable people in society. Although some cases focused on access to health care, some other cases clearly addressed the wider social determinants of health (social benefits, housing facilities, etc.). Although such cases address individuals rather than more general concerns, they can have a spillover effect when civil society and the media draw attention to such cases. This can spark a public debate about the position of these marginalized population groups more generally.

Case study 3 Latvian Constitutional Court, Latvia

In several cases, the Latvian Constitutional Court assessed the rights in the International Covenant on Economic and Social and Cultural Rights.⁵ For example, in a decision in 2000, the court addressed Articles 9 and 11 (the rights to social security) as well as General Comments 3 and 9.⁶ The latter is remarkable, as General Comments are in principle non-binding (soft law instruments).

ESCR-net, an international human rights network, indicates that in this particular case, 10 deputies of the Latvian Saeima (parliament) claimed that certain employers were not paying social insurance premiums into a fund for their employees. The deputies asserted a breach of the constitutional right to social security and of Articles 9 and 11 of the International Covenant on Economic and Social and Cultural Rights, since the State had failed to ensure the relevant legislation that obligated employers to pay premiums. According to ESCR-net:

The Court found that the law was inconsistent with the right to social security. The Court noted that General Comments 3 and 9 of the United Nations Committee on Economic, Social and Cultural Rights and the Limburg Principles had advanced the understanding of the more discrete obligations of Member States. The State had the discretion to choose the manner of implementation of the right to social security – in the Latvian case, a system of social insurance

(through premiums) and social assistance for those in need – but that the State must develop an efficient mechanism for the implementation of the norms in order to guarantee the right. Failure to collect taxes (or premiums) would not be a proper utilisation of all of its resources in implementing social rights. The Court acknowledged that the legislation was developed in a standardized and institutionalized way that several State institutions were authorized to oversee its implementation and there was a theoretical possibility that employees could bring a claim for compensation for violation of their constitutional rights. However, the law was inconsistent with the right to social security since it effectively allowed non-compliance by employers, to the detriment of employees.⁷

ESCR-net concludes: “The case demonstrates the potential for Constitutional Courts to apply international and constitutional standards on economic, social and cultural rights and monitor the implementation of programmes designed to realize social security rights, particular the regulation of private actors.”⁸

To assess this case on social security access, the Latvian Constitutional Court used international human rights law, including economic and social rights and soft-law instruments. The case as such clearly illustrates how Courts can use binding and non-binding international human rights instruments.

⁴ Decision of the Centrale Raad van Beroep (Central Appeals Court, the Netherlands) of 9 September 2011, LJN BT1738, 11/4654 AWBZ-VV. <http://jure.nl/bt1738>, accessed 22 October 2015.

⁵ See www.escr-net.org, accessed 22 October 2015.

⁶ Case No. 2000-08-0109 Constitutional Court of Latvia, see http://www.escr-net.org/caselaw/caselaw_show.htm?doc_id=400782, accessed 22 October 2015.

⁷ Case No. 2000-08-0109 Constitutional Court of Latvia, see http://www.escr-net.org/caselaw/caselaw_show.htm?doc_id=400782. For General Comment 3 see <http://www.fao.org/righttofood/KC/downloads/vl/docs/AH351.pdf>, and General Comment 9 see <http://www.unhchr.ch/tbs/doc.nsf/0/4ceb75c5492497d9802566d500516036?Opendocument>.

⁸ Case No. 2000-08-0109 Constitutional Court of Latvia, see http://www.escr-net.org/caselaw/caselaw_show.htm?doc_id=400782.

Case study 4

European Court of Human Rights, Strasbourg, France

The European Court of Human Rights (Council of Europe) was set up in 1959 to rule on applications alleging violations of the civil and political rights set out in the European Convention on Human Rights and Fundamental Freedoms. The Court has delivered more than 10 000 judgements, which are binding on the countries concerned. Although the Court addresses civil and political rights only, its decisions have led governments to alter their legislation and administrative practice in a wide range of areas, including health-related areas. Examples include the following.

1. The case of *McGinley and Egan v. the United Kingdom* concerned the exposure of service personnel to radiation for experimental purposes on Christmas Island. The Court assessed the right of access to records relating to applicants' participation in Christmas Island nuclear tests. Although the claim was rejected, it shows the willingness of the Court to deal with issues relating to occupational and environmental health.⁹ Environmental health and safe housing conditions were at issue in the case of *Öneriyildiz v. Turkey*. In this case, a methane explosion at a rubbish tip caused the death of 39 slum dwellers. The Court decided that there was a violation of the right to life in Article 2 of the European Convention on Human Rights and Fundamental Freedoms:

Since the Turkish authorities had known or ought

to have known that there was a real or immediate risk to persons living near the rubbish tip, they had had an obligation under Article 2 of the Convention to take such preventive operational measures as were necessary and sufficient to protect those individuals, especially as they themselves had set up the site and authorised its operation, which had given rise to the risk in question.¹⁰

2. In the case of *Cyprus v. Turkey*, people from the Northern part of Cyprus were not allowed to travel to the southern part to seek health services.

An issue may arise under Article 2 of the Convention where it is shown that the authorities put an individual's life at risk through the denial of healthcare which they have made available to the population generally.¹¹

3. The case of *Zehnal and Zehnalova v. the Czech Republic* concerned the fact that many public buildings in the applicants' home town were not equipped with access facilities for people with disabilities. Although the Court declared the case not admissible, it recognized the link between the right to private and family life and such measures requested by the applicants.¹²

This overview illustrates how this influential court is increasingly engaged with issues touching on social determinants of health. The Courts' decisions are not always warmly received. The Court has been criticized by several states parties for interfering too deeply in the states' domestic affairs and for not respecting a broad margin of appreciation.¹³

In conclusion, judicial decisions always address particular cases rather than a trend or an issue that affects a broad section of society or society at large. Nevertheless, as also discussed by Yamin, it is misleading to view litigation as entirely distinct from political strategies for attaining health rights. Litigation can have significant implications

for policy-making and spending. This is particularly visible in the well known Treatment Action Campaign case in South Africa, which ensured the accessibility of the drug nevirapine for preventing the mother-to-child-transmission of HIV, beyond a number of pilot sites (49).¹⁴ As described by Forman, "the [Treatment Action Campaign] court

⁹ ECtHR *McGinley and Egan v. The United Kingdom*, judgment of 9 June 1998, no.10/1997/794/995-996.

¹⁰ ECtHR 30 November 2004, *Öneriyildiz v. Turkey* (GC), no. 48939/99.

¹¹ ECtHR 10 May 2001, *Cyprus v Turkey*, no. 25781/94, paragraph 219.

¹² ECtHR (dec.), no. 38621/97, ECHR 2002-V.

¹³ For example, based on the Hirst decision of the ECtHR, which recognized the right to vote of prisoners in the UK, members of the UK Parliament have criticized the power of the ECtHR to rule counter to the decisions of Parliament. See also Pinto-Duschinsky, *Bringing rights back home: making human rights compatible with parliamentary democracy in the UK*, 2011.

¹⁴ *South Africa Minister of Health v. Treatment Action Campaign* (No. 2), 2002 (5) SA 721.

case, together with surrounding media furore, precipitated a discernable shift in how the appropriateness of TRIPS and patents came to be seen” (57). Although the case is less

relevant to a European context, it illustrates how a particular court case can have a spillover effect and lead to subsequent policy changes.

4.4 Quasi-judicial accountability

Unlike judicial bodies, quasi-judicial bodies are not always completely independent and/or their decisions are not binding. Examples include national ombudspersons, the Human Rights Committee (the United Nations

treaty-monitoring body of the International Covenant on Civil and Political Rights) and the European Committee of Social Rights (Council of Europe’s treaty-monitoring body of the European Social Charter).

Case study 5

The Human Rights Ombudsman, Slovenia

The Human Rights Ombudsman of the Republic of Slovenia was instituted in 1994, under the Slovenian Constitution and Human Rights Ombudsman Act. The Ombudsman is an independent body that addresses individual complaints in which state and local administration authorities might be held accountable for the alleged human rights violations. Although its decisions and actions are not legally binding, they do have the potential to warn institutions about improper conduct and demand necessary actions to resolve it. The Ombudsman can also collaborate with the public (such as NGOs and media) to strengthen the effect of its decisions. Nearly 3000 cases are investigated every year.¹⁵ We outline two cases related to social determinants of health.

Unequal opportunities in education

In July 2009, the Ombudsman initiated an enquiry into the issue of unequal opportunities in education, as a response to a newspaper article that stated that students in the Pormuje region have poorer academic results than the students in the Nova Gorica region. This issue was seen as a violation of children’s right to education. The Ombudsman argued that schools in the Pormuje region might not be fulfilling their educational obligations satisfactorily, thereby harming the students’ opportunities for acquiring the desired profession and earnings. In accordance with the recommendations of the Commission on Social Determinants of Health, the Ombudsman also noted that better education

is a prerequisite for a healthier lifestyle and longer lifespan.¹⁶ However, it was unclear whether further action was taken besides these denunciations.

Hazardous environmental effects

In 2009, a citizen’s group complained to the Ombudsman about the disturbing and hazardous effect of the new biogas plant in the village of Motvarjevci in Premurje region. The Ombudsman stated that, although the biogas plant had acquired all the permits, its location was both unsuitable and wrongly selected. The Ombudsman touched on the aspect of civil participation by arguing that it was difficult to determine whether the local community was involved in planning the plant. Instead of providing high-quality solutions on the use of land and environmental protection, the Ombudsman stated that the local government was mainly concerned with short-term capital gains, thereby overlooking the lasting impact on the environment of such decisions. As a result, the initiative by the citizen’s group was declared well grounded.

Since these two cases were highlighted in a report rather than in the form of a decision, we are uncertain about the effect of the Ombudsman’s actions in changing harmful social conditions. We nevertheless observe that, although individuals, specific groups or media brought the cases, this report enabled the Ombudsman to draw attention to matters that affected the population at large.

¹⁵ See <http://www.varuh-rs.si>, accessed 22 October 2015.

¹⁶ See <http://www.varuh-rs.si/publikacije-gradiva-izjave/govori-referati-in-clanki/novice/detajl/do-poorer-achievements-of-pupils-from-individual-regions-constitute-a-violation-of-human-rights/?L=6&cHash=bf120bcefb>, accessed 22 October 2015.

The National Ombudsman of Slovenia has several other tools to address social injustices. The Ombudsman can suggest changes of statutes and other regulations to the government or other bodies to prevent such violations to occur; request the Court to review the constitutionality and legality of a particular case; file a constitutional

complaint about the violation; and put pressure on (local) government or other bodies that oversee the work of a particular private company.¹⁷ In situations like the ones addressed in the reports, it could be worth considering which additional options are open to the Ombudsman to draw more attention to the topics at issue.

For the purposes of this study, it is important to draw some attention to the practice of the European Committee on Social Rights, which monitors compliance with the European Social Charter (Council of Europe). Organizations entitled to do so can submit a collective complaint regarding the alleged violations of the rights protected by the Charter, which can lead to a non-

binding decision of the Committee and a subsequent adoption of a resolution of the Committee of Ministers of the Council of Europe. Although the health situation of a vulnerable population group was at issue in some decisions, in various other cases the underlying determinants of health were addressed (Table 10).

Table 10. Examples of accountability at the regional level: the practice of the European Committee of Social Rights

Name and date of decision	Rights at issue	Issues Issue addressed
<i>Marangopoulos v. Greece</i> (30/2005)	11, 2, and 3 (safety at work and healthy working conditions)	Working conditions of people working in lignite mines
<i>ATD Fourth World v. France</i> (33/2006)	16, 30, 31, E	Denial of access to housing of people in extreme poverty
<i>INTERIGHTS v. Croatia</i> (45/2007)	11, 16 (protection of the family) and 17 (protection of children)	Access to sexual and reproductive health education in schools
<i>ECCR v. Bulgaria</i> (46/2007)	11, 13 (medical assistance) and E (non-discrimination)	Access to health services for the Roma and their general health conditions
<i>DCI v. the Netherlands</i> (47/2008)	11, 13, 16, 17, 30 (housing) and 31 (protection against poverty and exclusion)	Access to housing and other facilities for “undocumented” children
<i>FIDH v. Greece</i> (72/2011)	11 (protection of health)	Industrial pollution

Sources: European Committee of Social Rights and the authors.

Case study 6

European Committee of Social Rights, Strasbourg, France

The European Committee of Social Rights monitors compliance with the European Social Charter. Organizations entitled to do so can submit a collective complaint regarding the alleged violations of the rights protected by the Charter, which can lead to a non-binding decision of the Committee and a

subsequent adoption of a resolution of the Committee of Ministers of the Council of Europe. So far, the Committee has handed down about 40 decisions.¹⁸ Below, we discuss three cases in which the health of a vulnerable population was at issue.

¹⁷ See <https://mail.abdn.ac.uk/owa/redir.aspx?C=ae8867f8d5274da5bcf25d506fdb5b9d&URL=http%3a%2f%2fwww.varuh-rs.si%2fiscete-pomoc%2fkako-vam-lahko-varuh-pomaga%2fkaj-varuh-lahko-stori%2f%3fl%3d6>, accessed 22 October 2015.

¹⁸ http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp, accessed 22 October 2015.

Access to health care and unhealthy living conditions

In the decision of *ECCR v. Bulgaria*, the Committee established that the health status of the Roma population is inferior to that of the general population and considers that the State has “failed to meet its positive obligations to ensure that Roma enjoy an adequate access to health care”. The State had particularly failed to “take reasonable steps to address the specific problems faced by Roma communities stemming from their often unhealthy living conditions and difficult access to health services” (paragraph 49).

Living conditions and housing

In several other decisions, the Committee has addressed the lack of access to appropriate housing facilities. In *DCI v. the Netherlands*, the Committee decided that the denial of entitlements to shelter to children unlawfully present in the Netherlands constituted a violation of the right to housing and the right to protection against poverty and social exclusion in the European Social Charter. In the second case study (Fischer Advocaten), it was illustrated how the decision in *DCI v. the Netherlands* has enabled domestic legal practice in the Netherlands to work in the scope of the right to privacy and family life in Article 8 of the European Convention on Human Rights and Fundamental Freedoms.¹⁹

This section has made it clear that quasi-judicial bodies, such as national ombudspersons and the European Committee of Social Rights, use the human rights framework to address harmful health conditions. They are in a position to critically assess whether the state parties are fulfilling their obligations in both individual and collective cases. Since these institutions publish their decisions and reports publicly, it enhances state parties’ transparency, which

Administrative accountability means using norms and mechanisms for holding people and departments within government administration accountable. Increasingly,

Environmental and occupational health

The Committee has also addressed the issue of environmental and occupational health on several occasions. In the case of *Marangopoulos Foundation for Human Rights (MFHR) v. Greece*, it was alleged that the Greek government was not adequately preventing the environmental impact of lignite mining and that the safety and working conditions of people working in the mines were not guaranteed. The Committee concluded that several articles in the European Social Charter were violated, including the right to protection of health in Article 11. A recent complaint from the International Federation for Human Rights against Greece was registered on 8 July 2011. It concerned the effects of massive environmental pollution on the health of people living near the Asopos River and near the industrial zone of Inofyta, located 50 km north of Athens. The complainant organization alleged that the Greek government did not take adequate measures to eliminate or reduce these dangerous effects and to ensure the right to health protection, thereby violating Article 11 of the European Social Charter.²⁰

The cases described above illustrate that the European Committee of Social Rights is increasingly engaged with a wide range of health-related conditions. Although the decisions of this body are not legally binding, they are gaining authority because scholars and civil society increasingly refer to them.

in turn creates a reference source for civil society and scholars to build upon in their respective mobilizing activities. Since the decisions and reports are not binding, one could argue that their effect is not as strong as legally binding decisions. Although we should not overestimate the importance of a decision being legally binding, the decisions of the European Committee of Social Rights and of national ombudspersons are gaining in importance and influence.

4.5 Administrative accountability

human rights impact assessment is being used. Human rights impact assessment is designed to predict the potential consequences of a proposed policy, project or

¹⁹ DCI v. the Netherlands, complaint no. 47/2008, see http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp.

²⁰ FIDH v. Greece, complaint No. 72/2011, see http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp.

trade agreement on the enjoyment of human rights. A distinction can be made between corporate human rights impact assessment and government human rights impact assessment. As to government human rights impact assessment, a comprehensive report by Hunt & McNaughton describes several

interesting initiatives, including the initiative of Aim for Human Rights that is presented below (58). In addition, government bodies themselves are increasingly submitting their own plans and policies to human rights impact assessment (see below Aberdeen City Council).

Case study 7

Aberdeen City Council, Scotland, United Kingdom

The Equality and Human Rights Impact Assessment of Aberdeen City Council aims to assess the impact of the Council's policies, procedures and functions on the diverse groups within Aberdeen City.²¹

The Equality and Human Rights Impact Assessment focuses on nine protected characteristics as well as human rights. The related equality groups are age (younger and older people); disability; gender reassignment (including transgender); marriage or civil partnership; pregnancy and maternity; race (people from ethnic minorities including refugees and Gypsies/Travellers); religion or belief (people from different religions, including those with no religion or belief); sex (formerly gender); and sexual orientation.²²

As a framework for the assessments, the principles of direct and indirect discrimination are mostly used, but also the rights set out in the European Convention on Human Rights and Fundamental Freedoms and the United Nations Convention on the Rights of the Child, as well as national legislation, in particular the Equality Act 2010.

All proposals, including new functions, policies and procedures should go through the Equality and Human Rights Impact Assessment process. This process contains the following steps: (1) identify essential information; (2) outline the aims of the proposal; (3) gather and consider evidence; (4) assess likely effects on the protected characteristics; (5) apply the three key assessment tests for assuring human rights

compliance; (6) monitor and review; and (7) sign off. As part of steps 3 and 4, a set of questions is to be addressed to assess the consequences of a new proposal in relation to all the above-mentioned groups. A question that may have to be asked is, for example: How might the proposal affect ethnic minorities, including Gypsies and/or Travellers? In relation to step 5, the following rights are in particular mentioned: the prohibition of torture, the right to a fair and public hearing, the right to respect for privacy and family life, freedom of expression, non-discrimination and the right to education.

Roddy MacTaggart from Aberdeen City Council states the following about this procedure.

The tool is used on a consistent basis, for example during recent budget considerations a proposal to cease payments from the Fairer Scotland Fund was rejected since withdrawing this funding would have detrimental impacts on ethnic minorities, people with disabilities, women (in particular single parents and women carers), older people and people experiencing poverty. We clearly see an improvement in the degree of understanding of human rights by officers. ...

The Equality and Human Rights Impact Assessment of Aberdeen City Council forms a clear example of how human rights are successfully used in relation to the social determinants of health. International human rights norms are translated into a concrete tool that is consistently used by community officers in practice. The process leads to concrete improvements of the living conditions of Aberdonians.

²¹ <http://www.aberdeencity.gov.uk/nmsruntime/saveasdialog.asp?IID=21290&slD=2603>, accessed 22 October 2015.

²² <http://www.aberdeencity.gov.uk/nmsruntime/saveasdialog.asp?IID=21290&slD=2603>, accessed 22 October 2015.

Aim for Human Rights/Rights4Change, the Netherlands

Aim for Human Rights was an independent Dutch NGO founded by three humanist organizations in 1981 (now continued under a new name: Rights4Change). Its Human Rights Impact Resource Center takes important initiatives in relation to human rights impact assessment.

The Health Rights of Women Assessment Instrument is a strategic tool and resource guide adopted by Aim for Human Rights/Rights4Change to enhance lobbying activities for better implementation of women's health rights. The Health Rights of Women Assessment Instrument analysis comprises six steps that analyse a certain policy that is linked to a women's health problem in their daily lives. Each step consists of information and questions to guide the analysis. Explanations, examples and checklists facilitate the answering of the questions. The analysis produces a set of recommendations to improve the impact of the policy as well as an action plan to lobby for adopting the recommendations.²³

The following example demonstrates how the tool has been used in practice. In April

2008, a modification of the Dutch health-care insurance law was proposed and analysed using the Health Rights of Women Assessment Instrument. In the Netherlands, undocumented women were supposed to visit specifically designated clinics during their pregnancy to receive health care. The clinics involved would only be reimbursed for 80% of the costs they incurred for these women. Since clinics might not treat women if they did not receive the full refund of their induced cost and since the women might not be able to find the specifically designated clinics, this proposed modification would reduce access to health care among undocumented women in practice. Aim for Human Rights argued that, from a human rights perspective, a government is not allowed to reduce the level of health care to any women, undocumented or not. Dutch NGOs therefore recommended that policy-makers change the reimbursement to 100%, which was eventually accepted.²⁴

The above demonstrates how a human rights impact assessment of a government proposal can lead to a policy change, protecting the human rights of a vulnerable group.

As illustrated, impact assessment can successfully address harmful social determinants of health and address larger

population groups. We therefore carefully conclude that in both case studies there was a certain social outcome (56).

Political accountability at the national level means holding the state accountable for violations of the health-related rights through the actions of political bodies, including parliamentary committees, health councils, but also through elections (46). For example, parliamentary committees can investigate general issues (a trend) or a more specific problem in relation to health inequities. In the

4.6 Political accountability

process of such investigations, civil society can be asked to participate by means of public hearings or the hearing of witnesses, illustrating how social accountability can be intertwined with political accountability. At the international level, political accountability means using international mechanisms for generating political attention focused on violations of the health-related rights.

²³ HeRWAI, available at http://www.humanrightsimpact.org/fileadmin/hria_resources/HeRWAI_Training/HeRWAI_engels_2010.pdf, accessed 22 October 2015.

²⁴ See <http://www.humanrightsimpact.org/themes/womens-human-rights/herwai>, accessed 22 October 2015.

Case study 9

Senate Subcommittee on Population Health, Canada

The Senate Subcommittee on Population Health was established in 2007 with the aim of examining and reporting on the social determinants of health in the Canadian population. It also investigated the effects of social determinants of health on existing health disparities and inequities.²⁵

In June 2009, the Subcommittee submitted *A healthy, productive Canada: a determinant of health approach* to the Senate, in which it clearly stated the premise that health is a basic human right. Good health for all is a responsibility of society as whole, and a prerequisite for individuals and communities to function well. As such, the Subcommittee purported the following.

Governments have a moral obligation to foster the social, economic, cultural and environmental conditions that empower individuals and communities to create and maintain good health for all citizens.

To achieve this, the Subcommittee believed that population health policy and whole-of-government approaches – varying from education to economic policy, through environmental and food policy – were needed. The report contained 22 recommendations,

mostly in accordance with the findings of the Commission on Social Determinants of Health. These recommendations were grouped into four categories: governance, population health data infrastructure, healthy communities and Aboriginal peoples. They were directed at all orders of governments and sectors both within and outside the health discipline.

Since the Subcommittee did not request a formal federal government response, the Senate adopted the report without clearly defining a process for governments and other bodies to implement and act on these recommendations.²⁶ Thus far, these recommendations have not been implemented.

By promoting the premise that health is a basic human right, the Subcommittee on Population Health indirectly used the human rights framework in its report to address the social determinants of health and health inequalities in Canada. Unfortunately, although the Senate adopted the report, the Subcommittee failed to encourage the government to implement its recommendations.

Case study 10

Joint Committee on Human Rights, United Kingdom

The Joint Committee on Human Rights comprises 12 members appointed from both the House of Commons and the House of Lords. The Committee is charged with considering human rights issues in the UK but cannot take up individual cases.²⁷

In its 18th report of July 2007, the Joint Committee on Human Rights discussed the issue of victimization and neglect of older people within the health-care system. For this report, the Committee collected evidence

on how the human rights principles can be applied by health-care providers to ensure that older people receive adequate care with both dignity and respect.²⁸

The report stated that inadequate care provided to vulnerable older people is “a serious and severe human rights abuse” that violates national and international human rights law and common law. Moreover, the Committee asserted that the failure to respect the human rights of older people was a result

²⁵ *A healthy, productive Canada: a determinant of health approach. Final report of Senate Subcommittee on Population Health*, June 2009; see <http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/rephealthjun09-e.pdf>, accessed 22 October 2015.

²⁶ The Population Health Promotion Expert Group of the Pan-Canadian Public Health Network, October 2009; see <http://www.phn-rsp.ca/pubs/ssphfr-rfscssp/index.html>, accessed 22 October 2015.

²⁷ UK Parliament Website, Joint Committee on Human Rights; see <http://www.parliament.uk/business/committees/committees-a-z/joint-select/human-rights-committee/role>, accessed 22 October 2015.

²⁸ UK Parliament Website, Joint Committee On Human Rights, Eighteenth Report; see <http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/15604.htm>, accessed 22 October 2015.

of the power imbalance between service providers and service users and of the historic and embedded ageism within health-care system. It argued that the current legislation failed to protect and promote the rights of older people in health care.

In addressing this issue, the report recommended the government respect the Human Rights Act and Article 8 of the European Convention on Human Rights and make the human rights approach should integral to policy-making in health and social care. In this regard, the Committee made the following important statement.

We recommend that the Government, other public bodies and voluntary organisations should publicly champion an understanding of how the recognition of human rights principles can underpin a transformation of health and social care services. This should lead to a greater understanding of human rights in civil society and more effective implementation of the [Human Rights Act] within public authorities.²⁹

Further, the report acknowledged that the care providers have a positive duty to promote equality for older people and that age discrimination should be strictly prohibited in health-care provision. The Committee further recommended that care providers receive human rights training to ensure that older people receive treatment with dignity and respect. It also recommended that older people be informed about human rights so that they can raise questions if services are inadequate.

In this case study, the human rights framework under the Human Rights Act and the European Convention on Human Rights and Fundamental Freedoms were used to address the victimization and neglect of older people. This framework was also clearly used in formulating specific recommendations.

Case study 11 *United Nations Special Rapporteur on the Right to the Highest Attainable Standard of Health, Sweden*

Among various other United Nations human rights procedures, there are special rapporteurs. Special rapporteur is a title given to individuals working on behalf of the United Nations within the scope of Special Procedures mechanisms, who bear a specific mandate from the United Nations Human Rights Council.³⁰ Special rapporteurs are independent experts appointed by the Human Rights Council to examine and report back on a country situation or a specific human rights theme. Among other special rapporteurs, there is a Special Rapporteur on the Right to the Highest Attainable Standard of Health, a post currently held by Anand Grover.³¹

In 2006, the then-United Nations Special Rapporteur on the Right to Health, Paul Hunt, visited Sweden, where, among other issues, he addressed the lack of access

to health-care services for undocumented migrants. In his report, he states that:

Sweden's present law and practice places health professionals in a very difficult – if not impossible – position. Does a doctor turn away a sick, pregnant, undocumented woman who cannot afford to pay for the medical treatment she – and her unborn baby – needs? If so, what has become of the doctor's professional ethical duty to provide health care to the sick without discrimination?³²

The Special Rapporteur's visit sparked a public debate in Sweden and measures are currently taken to improve access to health care for undocumented migrants. Henry Asher, one of the public health experts involved in the campaign, puts it as follows.

I definitely think human rights have been extremely useful. We started the work as health professionals out from medical ethics and managed to build a smaller lobby network. We managed to put the issue a bit forwards. But

²⁹ See: <http://www.publications.parliament.uk/pa/jt200607/jtselect/jtrights/156/15613.htm>, accessed 22 October 2015.

³⁰ <http://www2.ohchr.org/english/bodies/chr/special/index.htm>, accessed 22 October 2015.

³¹ <http://www.ohchr.org/EN/Issues/Health/Pages/SRRightHealthIndex.aspx> and <http://www2.ohchr.org/english/issues/health/right/SRBio.htm>, accessed 22 October 2015.

³² Visit of the UN Special Rapporteur on the Right to the Highest Attainable Standard of Health, to Sweden from 10-16 January 2006, available at <http://www.temaasyl.se/Documents/Organisationer/FN/Paul%20Hunt%20Rapport.pdf>, accessed 22 October 2015, paragraph 4.

when Paul Hunt came the work really took a new turn. He introduced us to human rights, the United Nations criticism gave us courage and strength and our work received much more of recognition. The background to that was of course the self-image of Sweden as a leading human rights' country and that in the public opinion, human rights are important. The lobby network received many more organisations from all parts of the civil society. We would not have reached so far without human rights and Paul Hunt's report on Sweden. As Paul Hunt expressed it: 'When

human rights lawyers, health professionals and NGOs can work together on expanding human rights, then it will be much more relevant and successful.³³

Although the issue of access to health care for undocumented migrants is not specifically connected to underlying determinants of health, this case demonstrates how international action based on human rights can provoke changes at a national level.

Case study 12

United Nations General Assembly

In September 2011, the United Nations held a High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. During the Meeting, the government representatives drafted a Political Declaration, in which they acknowledge that noncommunicable diseases are one of the major challenges in the 21st century, compromising social and economic development throughout the world, especially in low- and middle-income countries.³⁴

The Political Declaration noted that noncommunicable diseases both lead to and result from significant health and social inequalities between countries and within countries and populations, disproportionately affecting people living in vulnerable situations. Further, the social determinants

were recognized as contributing factors to the increasing incidence and prevalence of noncommunicable diseases.

Importantly, the Political Declaration reaffirmed "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health", thereby holding governments accountable for its realization. It also acknowledged that collective and multisectoral public policies are required on the local, national, regional and global levels, to reduce the impact of the social determinants and risk factors. Here, the human rights approach is thus related not only to the issue of noncommunicable diseases itself but also to the social determinants.³⁵

In these case studies, international and national political bodies used the human rights framework to hold governments accountable for its realization. The Joint Committee in the United Kingdom (case 10) clearly used the human rights framework to address the poor care for older people and recommended that the government embrace human rights in health and social care issues. In the case study of the Canadian Subcommittee, the human rights approach was used indirectly to put the issue of health inequities on the political agenda (though unsuccessfully). At an international level,

the United Nations Special Rapporteur on the Right to Health used the human rights framework to address poor access to health care for undocumented migrants in Sweden (case 11), while the General Assembly used the human rights framework to address the issue of noncommunicable diseases (case 12). We observe that the use of human rights language by a political body not only helps such bodies to hold governments accountable but can also offer such bodies a practical guide or a framework on which to base its actions.

³³ Comment by Henry Asher, Nordic School of Public Health, Gothenburg, Sweden.

³⁴ Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases, 16 September 2011; see http://www.un.org/ga/search/view_doc.asp?symbol=A%2F66%2FL.1&Lang=E, accessed 22 October 2015

³⁵ NCD Alliance Briefing Paper, *Non-communicable diseases and the rights-based movement*, July 2011; see [http://www.ncdalliance.org/sites/default/files/rfiles/NCDs%20and%20Human%20Rights%20-%20longer%20doc%20\(1%20July%202011\).pdf](http://www.ncdalliance.org/sites/default/files/rfiles/NCDs%20and%20Human%20Rights%20-%20longer%20doc%20(1%20July%202011).pdf), accessed 22 October 2015.

4.7 Social accountability

Social accountability refers to actions by civil society to oversee governmental conduct (46). This can take many forms: action by NGOs or other civil society movements and the media. We have come across a wide range of international and national NGOs that have been quite successful at times in drawing attention to health-related topics from the human rights perspective. While

the Seven Towers (case study 13) used the human rights framework as a political to achieve concrete results on the ground, the I Can Live Coalition (case study 14) induced change via the litigation process. The case study of Spain (case study 15) demonstrated that collaboration between international and national human rights NGOs is another possible way to strengthen one's actions.

Case study 13 *PPR/Seven Towers Project, Northern Ireland, United Kingdom*

The Participation and the Practice of Rights Project, based in Northern Ireland, seeks to support local communities and groups in using a human rights-based approach to address the social and economic deprivation they face.³⁶ In 2009, the Project had worked with four groups: the Seven Towers Residents Group (housing), the PIPS/Greater Shankill Bereaved Families Rights Group (mental health), the Girdwood Residents Jury (regeneration) and the Lower Shankill Residents Voice (play and regeneration). Each of these groups has used human rights indicators and benchmarks to assess whether the right to housing and other economic and social rights were being realized.

In 2009, the Project submitted a report to the United Nations Committee on Economic, Social and Cultural Rights. The report contained a detailed assessment of self-set indicators and benchmarks, which were based on several General Comments by the Committee on Economic, Social and Cultural Rights.³⁷ This led to the following recommendation of the Committee.

The Committee recommends that the human rights framework, including the Equalities Impact Assessment, be effectively implemented in Northern Ireland, particularly in the context of urban regeneration programmes by ensuring the

participation of the affected populations and the development of adequate policies and targeted measures to promote substantive equality, provide for improved health care, as well as an increase in skills training and employment opportunities for young people and adequate housing programmes for the poor and, in particular, Catholic families.³⁸

Since 2006, the Project has supported the Seven Towers Residents Group. Seven Towers is a high rise complex in North Belfast containing 380 high-rise flats in the Nationalist New Lodge area. Seven Towers has been rated as one of the most deprived areas in terms of unmet housing need in all of Northern Ireland.³⁹ The Seven Towers Group uses the framework of the right to housing and a set of self-set indicators and benchmarks to assess and monitor the housing conditions of the residents. The Project website reports the following.

Working through a "Monitoring Group" structure, the group have achieved significant improvements in the flats complex, including the complete removal of pigeon waste from communal landings and the replacement of the sewage system, which frequently overflowed through baths and sinks, and the rehousing of the majority of families into suitable accommodation.⁴⁰

This case study demonstrates that a local NGO can effectively use international human rights law to address poor housing conditions in a socially deprived area.

³⁶ <http://www.pprproject.org>, accessed 22 October 2015.

³⁷ PPR, 2009 submission to the United Nations Committee on Economic, Social and Cultural Rights, see http://www2.ohchr.org/english/bodies/cescr/docs/ngos/Participation_and_Practice_of_Rights_Project_UK_CESCR42.pdf, accessed 22 October 2015.

³⁸ CESCR, Consideration of reports (...), United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories, UN Doc. E/C.12/GBR/C/5, 4-22 May 2009, paragraph 31, available at www.ohchr.org accessed October 2011.

³⁹ <http://www.pprproject.org/right-to-housing>, accessed 22 October 2015.

⁴⁰ Ibidem. For more detailed information see also PPR, *A human rights budget analysis of the Northern Ireland Housing Executive's current plans to clad the Seven Towers Flats*, pp. 2-3, see <http://www.pprproject.org/sites/default/files/BUDGET%20ANALYSIS%20JUNE%202011.pdf>, accessed 22 October 2015.

Case study 14

I Can Live Coalition, Lithuania

In 2004, local Lithuanian NGOs collaboratively established the I Can Live Coalition (the Coalition), which aims to improve public health and protect vulnerable groups based on human rights, especially the right to health and other health-related rights. Although the right to health is embedded in the Constitution of Lithuania, vulnerable groups (such as people who use drugs, people living with HIV and sex workers) tend to have less access to health care and social services, because of the stigma and discrimination. The Coalition has various advocacy activities: meeting with policy-makers, organizing awareness-raising campaigns and working closely with the media. In this case study, we pay attention to the Coalition's advocacy on providing opioid substitution therapy to drug users.⁴¹

Opioid substitution therapy was not available to drug users in all municipalities in Lithuania.⁴² Even in the municipalities that provided opioid substitution therapy, accessibility was an issue. Due to limited state financing and political opposition, opioid substitution therapy providers were unable to provide opioid substitution therapy to all people who inject drugs. In addition, access to harm-reduction services was dramatically low, which potentially posed a risk to many people who inject drugs to contract infectious diseases. Partly because of the Coalition's efforts, Lithuania implemented some important policy changes.

In 2006, the Minister of Health issued the Order on the Description of the Procedure

for Narcotic and Psychotropic Substance Harm Reduction Programmes.⁴³ This legal act, to which the Coalition contributed a passage, defined for the first time in Lithuania the goals, objectives, implementation procedure and financial resources for the harm reduction programmes. It dramatically improved the services. Further, the Coalition played a significant role in the approval of the 2007 Order of the Minister of Health on Descriptions of the Procedure for Prescription and Application of Substitution Treatment to Treat Opioid Dependencies and Prescription, Dispatch, Storage and Accounting of Substitution Therapy Opioid Medications at Health-care Institutions.⁴⁴ This Order simplified the procedure for establishing pharmaceutical opioid therapy programmes. It also sets out that centres for dependence disorders must cover the costs of methadone therapy, which made methadone actually free for users. Moreover, the Coalition contributed to the drafting of the Dependence Disorder Treatment Programme for 2005–2008, which created opportunities for receiving funding for pharmaceutical methadone therapy and thus ensured the continuity of the programme.

The I Can Live Coalition mainly focuses on the right to health and other health-related rights to protect vulnerable groups. With its successful advocacy efforts in providing adequate services to people who use drugs, it sets an example on how a local NGO can use the human rights framework to address health inequities.

⁴¹ The content of this case study has mainly been drafted by Jurga Poskeviciute, member of the "I Can Live" Coalition, and revised by Umar Ikram. We acknowledge his input.

⁴² The content of this case study has mainly been drafted by Jurga Poskeviciute, member of the "I Can Live" Coalition, and revised by Umar Ikram. We acknowledge his input.

⁴³ Order of the Minister of Health of the Republic of Lithuania, On Approval of the Inventory of Drug and Psychotropic Substance Harm Reduction Programs Implementation Procedure, 5 July 2006.

⁴⁴ Lietuvos Respublikos Sveikatos Apsaugos Ministro Įsakymas, Del Pakaitinio Gydymo Skyrimo Ir Taikymo Priklausomybei Nuo Opioidu Gydyti Ir Pakaitiniu Opioidiniu Vaistiniu Preparatu Išrašymo Išdavimo, Laikymo Ir Apskaitos Asmens Sveikatos Priežiuros Įstaigose Tvarkos Aprašu Patvirtinimo, 6 August 2007.

Case study 15

Centre for Economic and Social Rights and Observatory of Economic, Social and Cultural Rights (Observatorio DESC), Spain

The Centre for Economic and Social Rights is an international NGO; the Observatory of Economic, Social and Cultural Rights (Observatorio DESC) is a local NGO in Spain. In April 2011, they collaborated to present a joint submission to the United Nations Committee on Economic, Social and Cultural Rights in response to the state report drafted by the Government of Spain.

This submission, yet to be reviewed by the Committee, outlines areas of concern under the International Covenant on Economic, Social and Cultural Rights that were inadequately addressed in Spain's official report to the Committee. A particular focus was the rights most affected by the economic crisis and the government's response to it, which lacked a human rights perspective. The submission also analysed the disparities in the enjoyment of the economic, social and cultural rights, thereby critically investigating Spain's commitment to its obligation of non-discrimination. The Centre for Economic and Social Rights and the Observatory of Economic, Social and Cultural Rights urge the Committee on Economic, Social and Cultural Rights to address these fundamental gaps in the report.⁴⁵

According to the submission, the proposed austerity measures by the Government of Spain undermine the function of social welfare measures to support the most vulnerable people and compromise the right to social protection. Since the crisis led to high unemployment rates, especially among

women, immigrants and adolescents, many people accepted jobs with less favourable conditions to make a living. This situation made them vulnerable to exploitation, abuse and insecurity. To illustrate this, in 2010, Spain had one of the highest in-work at-risk poverty rates in all the 15 countries that were EU members before 2004 (EU15). Further, only 1.5% of GDP is spent on family benefits in cash, services and tax measures, while Spain currently faces one of the highest rates of poverty among children in the EU, with significant income and health inequalities among children. The submission also states that Spain is not performing well in education, with one of the highest dropout rates in the EU, thereby failing to realize the right to education for all. The submission also discussed the discrimination and social exclusion faced by the Roma population, which are the cause of poorer outcomes in employment, housing, health and education.

This joint submission drafted by the two NGOs was intended to draw the attention of the Committee on Economic, Social and Cultural Rights to issues that were inadequately addressed in the report of the Government of Spain. By explicitly using the International Covenant on Economic and Social and Cultural Rights, the submission used the human rights framework to analyse a number of issues explicitly touching on health inequities. It remains to be seen what Committee on Economic, Social and Cultural Rights does with the findings in the submission.

4.8 Discussion

This chapter presented 15 cases representing five different forms of accountability. The cases covered a wide range of topics, varying from social care for people with disabilities (Birmingham City Council), to educational

inequalities (Ombudsman of Slovenia) and environmental health (European Court of Human Rights). Most of these cases directly addressed the social determinants of health, and some cases primarily dealt with access to

⁴⁵ CESR and Observatori DESC, List of issues in response to the 5th Periodic Report of Spain, 1 April 2011; see http://www2.ohchr.org/english/bodies/cescr/docs/ngos/CESR_ObsDESC_SPAIN_CESCR_PSWG46.pdf, accessed 22 October 2015.

health care (Special Rapporteur in Sweden, Subcommittee in the United Kingdom and Aim for Human Rights).

This section evaluates how effective human rights were in addressing social determinants of health in these case studies. In measuring

Human rights and accountability

Were the cases under scrutiny effective in generating accountability for the issues they addressed? In all the cases we examined and chose to include in this report, governments were held to account to some extent for harmful social determinants of health. There are differences, however, in terms of effectiveness between various mechanisms. We see a distinction here between litigation and actions by local NGOs on the one hand and more general actions (reports by national and international bodies) on the other. We observe that individual court cases have led to very concrete improvements for individuals or groups that were directly affected by the human rights violations (such as Birmingham City Council and Fischer Advocaten). Similarly, actions by local NGOs were sometimes successful as well. We described the Seven Towers/PPR project, which improved the living conditions of the people living in a deprived area in Northern Ireland. We also looked at how the Lithuanian I Can Live Coalition was successful in using litigation to enhance treatment and care for injecting drug users. Although this is an advantage of this local and targeted approach, we observe that court cases and local actions by NGOs in principle only benefit individuals or affected groups. Nevertheless, as we also asserted above, court cases can sometimes have a spillover effect. A court decision that solely has direct consequences for an individual or a group of people may precipitate a shift in how a certain health issue is seen and may eventually lead to changes at a policy level that ultimately affect a larger group of people. Court decisions set a precedent and a watermark regarding the state of the art reasoning about a particular issue.

Human rights and the impact for people on the ground

In terms of the effectiveness of the human rights framework, we also need to look at

the effectiveness of the human rights framework, we identify two levels: the effectiveness of human rights:

- for generating accountability; and
- in terms of impact for people on the ground.

The concrete impact of more general actions, on the other hand, was more difficult to measure. Although the reports of the National Ombudsman of Slovenia and the report of the Centre for Economic and Social Rights to Spain were worthwhile in terms of content, we were uncertain about their impact. We observe that, although a general human rights report can successfully draw attention to a particular issue, the results are less concrete and more difficult to measure. An advantage of more general actions, however, is that they can more effectively address the problems affecting a larger group of people, a general health problem or issues affecting the population at large. It is thus important that there be adequate follow-up to the publication of such a report, to ensure that governments respond to these reports and take subsequent action. We also discussed the application of human rights impact assessment, which civil society and government bodies increasingly use to assess the consequences of a planned law or policy in light of human rights law. Although the results are still preliminary, it is promising that a city like Aberdeen is applying this tool with some success to all of its planned policies.

Altogether, we observe that each type of action has its advantages and disadvantages. Rather than argue in favour of one particular type of action, we consider all of them to have potential to address the social determinants of health, but they may have to be strengthened in terms of effectiveness. Although examining the broader potential individual cases can have is important, observing the follow-up of a more general report or other action is also critical.

the impact of our case studies or at their success in a material sense and in a social

sense (56). As we have argued above, it is very difficult to measure whether a resulting decision in a case study has this effect or, in other words, whether it makes a difference for the people affected (success in a material sense). In our assessment of cases, we have come across several cases that clearly made a difference for the people affected, in particular the domestic legal cases and the actions of local NGOs. As mentioned above, national court cases and actions by local NGOs occasionally improved the social conditions of individuals or groups (Birmingham City Council, Fischer Advocaten, PPR/Seven Towers and I Can Live).

In addressing social determinants of health, ideally the case studies make changes for a larger group of people, a population group or society at large. We asserted that this success in a social sense of a case or its social outcome would be more difficult to measure, since here it concerns the wider effects of the case study on a population group or society at large (56). The human rights impact assessment described led to changes in government policies, and as such we assume that they had a broader effect on the communities and population groups affected (Aberdeen City Council and Aim for Human Rights). We also encountered the initiative of the former United Nations Special Rapporteur on the Right to Health, who addressed the poor access to health-care services for undocumented migrants in Sweden. The international attention he generated catalysed the work of local NGOs, leading to some policy changes aimed to improve health-care access for undocumented migrants residing in Sweden. As such, we carefully conclude that

Altogether, applying the human rights framework to issues raised by the social determinants of health framework is a relatively new endeavour. Given this context, these case studies can be seen as a rather promising start. In our interviews with several people who were involved in the various case studies, we have observed an increasing willingness to use the human rights framework to address social determinants of health and health inequities. Some indicated that, by using human rights, they were able to draw more attention to their case – not

these types of actions, which were directed at a wider group of people, in principle had a measurable impact or social outcome.

Hence, when it comes to the impact of the case studies, we observe that domestic court cases and local NGO activities can have a clear and measurable impact on the people that were directly affected. More general political actions and human rights impact assessment can potentially generate change for a larger group of people. The impact of general human rights reports remains difficult to measure and therefore less clear. We reiterate that this by no means implies that one type of action is necessarily preferable above another, but taking into account their potential shortcomings is important.

As a corollary issue, we also looked at how participatory measures were used in the cases. As we asserted above, participation is an essential component of an accountability process. We observe that, in most cases, a certain issue was addressed on behalf of a marginalized individual or population group, while it was not entirely clear how the person or group at issue was actively involved in the case. In the cases of Seven Towers/PPR and the Slovenian Ombudsman (citizens complained to the Ombudsman about the hazardous effects of the new biogas plan), the marginalized group was clearly actively involved in generating accountability for their case. The success of the Seven Towers/PPR group could possibly be associated with the active involvement of community members. We therefore conclude that participation of individuals and groups in the accountability process could be strengthened to enhance a positive outcome.

Conclusion

merely based on morality but also based on the notion that the government could be held accountable for violating the legally binding human rights laws. Overall, based on our assessment of several case studies, we conclude that the human rights framework has the potential capacity to effectively hold governments accountable for health inequities and its underlying social determinants. We hope the case studies we presented might act as a source of inspiration for various actors such as civil society, legal practitioners and governments.

5. Conclusions

Because the allocation of public resources influences the distribution of the social determinants of health inequalities, policies for tackling health inequities depend on political action. Although there is a widespread feeling that health inequities are unjust, there is also scepticism about the progress in implementing actual policies to reduce these inequities. The focus of the cross-cutting task group for the European review on social determinants of health and the health divide was on the possibilities that social justice and human right approaches offer to close the gap between rhetoric and performance, or, in other words, to translate rhetoric into actual policies.

The first part of this report developed an argument, based on social justice theories, as to why health inequalities are unjust. We argued that the capability to be healthy should be a central consideration of social justice in European countries, based on the central values of equal concern and respect and freedom of choice. The principle of equal opportunities to be as healthy as possible implies government responsibility to create conditions that make this ideal possible. This demands such a distribution of social determinants of health that each individual has the same possibility to lead a healthy life. In addition, we showed that this principle might conflict with other goods societies might have reason to value, including the distribution of wealth or individual freedom of choice. In practice, the political support for tackling health inequalities, based on processes of weighting these social values, should be settled in a deliberative political process.

In the second part of this report, we have identified the various human right instruments that offer opportunities to

support and promote health equity in a broad spectrum of policies that address social determinants of health. We have shown that human rights law offers a legally binding framework for holding governments accountable for human rights violations, both before national and international judicial and quasi-judicial bodies. Moreover, human rights can play a steering role in drafting new laws and policies. We have described several cases in which human rights instruments have successfully been applied to social determinants of health in a broad sense, in different European subregions, thereby focusing on examples of human right violations. Individual court cases as well as actions by local NGOs appeared to have led to very concrete improvements for individuals or groups that were directly affected by the human rights violations. In addition, court cases might sometimes have a spillover effect. For more general actions, such as the publication of a human rights report, the cases that we analysed show that this kind of reports can successfully draw attention to a particular issue. The concrete impact and results of this general actions are, however, more difficult to establish.

Equity, fairness and social justice issues are at the core of the issue of inequities in health. Commitment to these issues cannot be taken for granted in the political arena, however. We hope that the arguments developed in this report, relating to social justice and human rights, as well as the cases presented on the application of human right instruments, might inspire people in different European subregions to effectively implement policies that address social determinants of health and that are effective in tackling health inequities.

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Social justice and human rights as a framework for addressing social determinants of health

Final report of the Task group on Equity, Equality and Human Rights

Review of social determinants of health and the health divide in the WHO European Region

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