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THE SOCIAL DETERMINANTS OF HEALTH, HEALTH EQUITY, AND HUMAN RIGHTS

Audrey R. Chapman

ABSTRACT

This article explores the benefits of a rights-based approach to health according greater attention to the social determinants of health, health equity, and the power structure. It uses the report issued by the World Health Organization Commission on Social Determinants of Health (CSDH), Closing the gap in a generation: Health equity through action on the social determinants of health, as a lens through which to address these issues. After presenting a brief overview of the CSDH report, the article compares the document with a rights-based approach to health on three topics: 1) the social determinants of health and the underlying determinants of health; 2) health inequalities and inequities; and 3) power, money, and resources. The article argues that the right to health requires greater attention to the social determinants of health, health inequalities, and power dynamics than these topics have received to date.

INTRODUCTION

In a 2005 article, Philip Alston offered the analogy of two ships passing in the night, each with little awareness of the other, to characterize the relationship between the human rights and development communities. Employing the Millennium Development Goals (MDGs) as a lens, he showed that, although the agenda and interests of the two communities overlap considerably, neither embraces cooperation with any enthusiasm or conviction.¹ Much the same could be said about the character of the interaction between the health and human rights community and the social epidemiology and the social medicine communities. On the one side, work on the social determinants of health has rarely acknowledged the potential contributions of a human rights approach. On the other side, rights-based approaches to health, with some notable exceptions, have not engaged in a meaningful way with the growing body of research that demonstrates the significant impact of the social determinants of health and health inequalities on health status and population health.

The 2008 report of the World Health Organization Commission on Social Determinants of Health (CSDH) is an important example of the first tendency. While the report, *Closing the gap in a generation: Health equity through action on the social determinants of health* (hereafter *Closing the gap*), addresses many of the same issues as does the health and human rights community, its authors seems reluctant to acknowledge this common ground.² Even when the report uses rights-based terminology, it rarely cites relevant international human rights instruments or notes the potential contribution of United Nations human rights institutions. To offer examples, the report's first mention of the right to the highest attainable standard of health attributes the right to the Constitution of the World Health Organization and "numerous international treaties."³ Despite the Commission's commitment to achieving universal health care, *Closing the gap* does not refer to Article 12 of the International Covenant on

Economic, Social and Cultural Rights until page 158 of the 208-page report, and then only very briefly; nor does the CSDH acknowledge the role of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter the Special Rapporteur on the right to health) until page 173. The Committee on Economic, Social and Cultural Rights's seminal general comment on the right to "the highest attainable standard of health" warrants only a brief citation that is buried in the chapter on political empowerment and a listing as one of the proponents of health for all.⁴

This reticence to recognize the shared agenda and potential contribution of the human rights paradigm is particularly surprising in view of the Commission secretariat's recommendation that the CSDH adopt a rights-based approach as an appropriate conceptual framework to advance towards health equity through action on the social determinants of health.⁵ The secretariat's framework document explains:

Human rights offer more than a conceptual armature connecting health, social conditions and broad governance principles. . . . 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.⁶

Others have also noted the conspicuous absence of human rights in the CSDH report. Paul Hunt, the former Special Rapporteur on the right to health, expressed disappointment that, despite "the multiple, dense connections between social determinants and human rights," the report's human rights comment, while not absent, is "underdeveloped and understated" and "disappointingly muted."⁷ Although he recognized the contributions of the report, he characterized the work of the CSDH as "a series of missed opportunities."⁸

Like Paul Hunt, I suggest that proponents of the social determinants of health and rights-based approaches to health have much to contribute to one another. In contrast with Hunt, whose viewpoint

identified the contributions that human rights could bring to the work of CSDH, this article argues that the right to health requires greater attention to the social determinants of health, health inequalities, and power dynamics than these have received to date. A forthcoming companion article will build on Hunt's concerns to identify how the integration of a human rights paradigm could have strengthened the CSDH report and prospects for implementation of its recommendations.⁹ In the present article, after presenting a brief overview of the CSDH report, I compare the perspectives of the Commission and those working on health and human rights issues on 1) the social determinants of health and the underlying determinants of health; 2) health inequalities and inequities; and 3) power, money, and resources. Before proceeding, however, it is important to acknowledge that there is considerable diversity in all three communities — social medicine, social epidemiology, and human rights — to which this article will not be able to do justice. In addition, there is already a small group of researchers who bridge the divide between human rights and health equity work.¹⁰

THE CSDH REPORT: CLOSING THE GAP IN A GENERATION

The World Health Organization (WHO) launched the Commission on Social Determinants of Health (CSDH) in March 2005, with a mandate to marshal evidence on what can be done to promote health equity and to foster a global movement to achieve it. The multinational CSDH consisted of 20 commissioners chaired by Sir Michael Marmot, who is known for his pioneering work on the impact of social inequalities on health in the United Kingdom. Specifically, the CSDH was tasked with collecting, collating, and synthesizing global evidence on the social determinants of health and their impact on health inequity from countries at all levels of income and development, and with making recommendations on actions to address this inequity.¹¹ To pursue its mandate, the Commission established a series of subject-matter working groups, termed "knowledge networks," on nine topics: globalization, early childhood development, employment conditions, women and gender equity, social exclusion, health systems, priority public health conditions, urban settings, and measurement and evidence.¹² The resulting report, *Closing the gap*, builds upon and gives greater visibility to prior work in the field of social medicine. Its major contributions are the visibility it gives to the social

determinants of health, its justice oriented trajectory, the extensive research it marshals, and its body of recommendations.

Using language rarely, if ever, seen in a WHO document, the final report is unequivocal in condemning the disparities in life opportunities and health status between rich and poor countries and between the rich and poor “within countries”:

Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health. It does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. . . . Putting right these inequities — the huge and remediable differences in health between and within countries — is a matter of social justice. . . . Social injustice is killing people on a grand scale.¹³

The Commission ascribes these differentials to “a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.”¹⁴ The report makes three overarching recommendations: 1) “improve the conditions of daily life — the circumstances in which people are born, grow, live, work, and age”; 2) “tackle the inequitable distribution of power, money, and resources” that serve as “the structural drivers of those conditions of daily life — globally, nationally, and locally”; and 3) “measure the problem, evaluate actions, expand the knowledge base” in order to understand the problem and assess the impact of action and “raise public awareness about the social determinants of health.”¹⁵ As the title of its report attests, the Commission

calls for closing the health gap in a generation (that is, within 30 years). While acknowledging that this is more likely an aspiration than a realistic goal, the CSDH expresses the belief that it is possible to achieve marked improvement in health equity within that time.¹⁶

Social determinants and the underlying determinants of health

So what are the social determinants of health? Put simply, the social determinants of health are the conditions in which people are “born, grow, live, work, and age,” and which shape their health status. The CSDH’s conceptualization of the social determinants of health reflects recent thinking in the social medicine literature whereby the role of social determinants is viewed as a community attribute, as well as a factor influencing individual health status.¹⁷ *Closing the gap* underscores that “the poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by . . . [differences] in the immediate, visible circumstances of peoples’ lives — their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities — and their [concomitant] chance of lead a flourishing life.”¹⁸ In turn, the CSDH argues that these inequalities reflect the unequal distribution of power, income, goods, and services, globally and nationally that are then translated into inequitable “social policies and programs, unfair economic arrangements, and bad politics.”¹⁹ The CSDH views both the conditions of daily life and the underlying structural determinants that shape them as together constituting the social determinants of health.

Paul Hunt argues that a rights-based approach to health, at least as it has developed in recent years, is also concerned with the social determinants of health.²⁰ Hunt is correct up to a point, but there also are significant differences between the way the two communities have conceptualized and approached this subject, as well as the emphasis they place on it. The difference in the terminology usually used — *social* determinants of health on one side and *underlying* determinants of health on the other — reflects other divergences in perspective.

On the human rights side, Article 12.2(b) of the International Covenant on Economic, Social and Cultural Rights, drafted some 50 years ago, enumer-

ates the “improvement of all aspects of environmental and industrial hygiene” as one of the four steps to be taken by state parties to achieve the full realization of the right to the enjoyment of the “highest attainable standard of physical and mental health.”²¹ Article 24(c) of the more recently drafted Convention on the Rights of the Child stipulates that the right to health includes access to nutritious food, clean drinking water, and environmental sanitation.²² Importantly, the Committee on Economic, Social and Cultural Rights General Comment 14 interprets the right to health as an inclusive right extending not only to timely and appropriate health care, but also to the underlying determinants of health. These, according to the Committee on Economic, Social and Cultural Rights (or CESCR Committee), include access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information.²³ Availability, discussed in paragraph 12(a) of the CESCR Committee’s General Comment 14, constitutes one of the four interrelated and essential elements of the right to health; here the Comment states the need to evaluate the sufficiency of “the underlying determinants of health,” as well as of the functioning public health and health care facilities, goods, and services such as hospitals, clinics, trained medical professionals, and essential drugs.²⁴ The delineation of core obligations in this general comment, which are responsibilities incumbent on all States parties regardless of the availability of resources, includes requirements to ensure access to the minimum essential food that is nutritionally adequate and safe and to ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water.²⁵ In addition, the general comment avers that patterns of health and ill-health are shaped by discrimination, poverty, and exclusion and that both biological and socio-cultural factors play a significant role in influencing health.²⁶ The CESCR Committee also took an unprecedented step when it adopted a general comment on the right to water, a right which is not explicitly enumerated in the International Covenant from which the CESCR Committee derives its mandate — in part because it viewed access to clean water as inextricably related to the right to health.²⁷

From the outset, Paul Hunt’s reports as Special Rapporteur portrayed the right to health as necessarily incorporating the underlying determinants while

acknowledging that his expansive view of the right is not universally held. When mentioning the establishment of the CSDH in his 2005 report to the UN General Assembly, Hunt proffers that “[t]here 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.”²⁸ Another of his reports lists gender, poverty, social exclusion, water, sanitation, nutrition, housing, and education as social determinants of health, and in that context, again references the work of the CSDH.²⁹ His 2007 report to the General Assembly includes a section on two key underlying determinants — safe water and adequate sanitation — characterizing them as essential for the realization of the right to health and of other human rights as well.³⁰ Similarly, his 2008 report observes that an effective and integrated health system, encompassing health care and the underlying determinants of health, is central to the right to health.³¹ Space constraints in all of these documents prevent Hunt from presenting an in-depth discussion of how these underlying determinants shape the realization of the right to health.

However, the approach to the underlying determinants by members of the human rights community tends to be narrower both in concept and in emphasis from the role the social determinants of health play in the CSDH report. For example, Hunt distinguishes between the underlying determinants of health and the social determinants of health. He itemizes the former as safe water and adequate sanitation, adequate nutritious food and housing, healthy occupational and environmental conditions, and access to health-related education and information. In contrast, he conceptualizes the social determinants of health as social factors such as gender, poverty, and social exclusion.³² The CSDH has a far more comprehensive, and better integrated understanding of the role of social determinants than the human rights community does of the underlying determinants. A right-based approach, including its treatment of the underlying determinants, tends to identify the state’s obligations and assess the extent to which they are being fulfilled. Human rights work on the underlying determinants only very secondarily considers their role as factors that determine the health status and outcomes of individuals and communities. And one crucial social determinant — social class — is often missing from human rights discourse. In addi-

tion, human rights analysis tends to consider the underlying determinants of health individually and sequentially, thus missing the impact their interacting and cumulative effects can have on individuals and communities. Nor does a human rights approach link inadequacies and injustices in the distribution of the social determinants to a structural analysis of the way political, social, and economic forces in society shape life opportunities, as the CSDH tries to do.

Importantly, the relative emphasis on these two sets of determinants — the human rights community's view of underlying determinants and that of the CSDH report on the social determinants of health — also differs quite considerably. For example, of the 65 paragraphs in the Committee on Economic, Social and Cultural Rights' General Comment 14 interpreting “the right to health,” only five mention the underlying determinants of health. Much of the remainder of the General Comment 14 addresses obligations of the state related to the health system and health services. Moreover, the references to the underlying determinants tend to be lists rather than an explication of their influence on health outcomes. In contrast, the CSDH treats the health system as just another social determinant and confines its discussion of health services primarily to only one of the report's 17 chapters.

Closing the gap, as well as the extensive body of research and publications on which this report rests, makes a compelling case for viewing health systems and the people they serve within a wide social context. The CSDH report, and more broadly, the findings of the social medicine and social epidemiology communities, suggest that societies cannot improve the health status of their populations and reduce significant health inequalities solely or primarily by increasing the resources devoted to medical services. While necessary and significant, investments to improve availability of health services and enhance their quality and relevance cannot compensate for significant disparities in access to the social determinants of health. Therefore, social and economic policies that invest in the social determinants of health as something far more than the traditional narrow focus on health systems constitute a more promising health policy approach. If the goal of the right to health is to improve health status in a society, particularly of vulnerable groups, then it is vitally important for those working on rights-based approaches to health to pay far greater attention to the conditions in which

people “grow, live, work, and age” and to better understand how such conditions shape health and well-being.

There are a variety of ways through which rights-based approaches to health could incorporate a more robust treatment of social determinants. Human rights theorists have already called for a more transformative engagement between health and human rights that would build on work in social epidemiology.³³ Efforts to apply the findings of research on the social determinants of health could be one component. Others have advocated better balancing of individual and collective dimensions of rights, so as to be able to deal better with social determinants and health equity.³⁴ A more vigorous effort to address inequalities and inequities in health outcomes (discussed below) would also require greater attention to reducing disparities in access to the social determinants of health and require research and planning to achieve this objective.

Most importantly, many of the key social determinants of health identified in the CSDH report — access to nutritious food, safe working conditions, adequate housing, clean water, and education — are enumerated as rights or components of rights in the ICESCR. A human rights approach could build on the principle of the indivisibility and interdependence of rights to develop a more integrated perspective on the role the realization of these rights play in health outcomes. General Comment 14 specifies that the right to health is closely related to, and dependent upon, the realization of other human rights, among them the rights to food, housing, work, and education.³⁵ To date, however, indivisibility tends to be more of a rhetorical affirmation than a lens through which to analyze and advocate for the right to health. What is needed is greater attention to interpreting the right to health through this interdependent lens.

Health inequalities vs. inequities

The phrase “inequalities in health” connotes differences in health status independent of any assessment of cause or fairness. In contrast, the term “equity” is an ethical concept, implying fairness or social justice grounded in principles of distributive justice.³⁶ According to the Commission, health equity has two important components: improving average health and abolishing avoidable inequalities in health within countries. Much like a human rights approach, the

CSDH report states that, in both cases, the emphasis should be on improving the health status of the worst off. However, the CSDH goes beyond a human rights approach in two significant ways. First, its strategy is to tackle the underlying structural determinants that generate stratification and social class divisions in the society, and that define individual socioeconomic position within hierarchies of power, prestige, and access to resource.³⁷ Second, its goal is to bring the level of those who are worst off to the level of those in society who are best off.³⁸

CSDH defines health inequity as the existence of systematic differences in health between and within countries that are deemed to be “avoidable by reasonable action.”³⁹ *Closing the gap* documents pervasive health disparities both between and within nations across the globe, and it also condemns these inequities as avoidable, unfair, unjust, and unacceptable. Decrying that “social injustice is killing people on a grand scale,” it calls on the international community to rectify health inequalities and to do so with a strong sense of urgency. Indeed, the report demands that “the appalling unfairness we see around the world be placed at the top of the agenda for global, regional, and national action.”⁴⁰

One of the goals of the CSDH is to establish the pathways that explain health disparities and inequities. According to the CSDH, the social determinants of health inequalities operate through a set of intermediary determinants of health to shape health outcomes. The three categories of intermediary determinants of health identified are 1) material circumstances (such factors as housing and neighborhood quality, the financial means to buy such items as healthy food and warm clothing, and the physical work environment), 2) psychosocial circumstances (such factors as psychosocial stressors, stressful living circumstances and relationships, and social support and coping styles or the lack thereof), and 3) behavioral and biological factors (including nutrition, physical activity, tobacco consumption, and alcohol consumption). All of these are distributed differently among constituent social groups.⁴¹

The CSDH also implicates the structural determinants or structural drivers in health inequalities and inequities. It proposes that social, economic, and political mechanisms within a particular society give rise to a set of sociopolitical positions whereby populations are stratified according to income, gen-

der, education, occupation, race, ethnicity, and other factors. In turn, these socioeconomic positions shape specific determinants of health status reflective of people’s place within social hierarchies.⁴² According to the Commission, the unequal distribution of power, income, goods, and services in each society gives rise to fundamental inequalities in the distribution of the social determinants of health.⁴³ In turn, these differentials translate into inequitable social policies and programs and unfair economic arrangements that perpetuate inequalities.⁴⁴

The CSDH report suggests that the concept of “social gradient” in health plays a central role in perpetuating inequities. Using work in social epidemiology, the report discusses the systematic correlation between social standing and health outcomes. As one ascends the socioeconomic ladder, advances in social standing are paralleled by improvements in health, and conversely, the greater the social disadvantage, the worse the health. To put the matter another way, the relationship between socioeconomic standing and health is on a continuous gradient. Those who are positioned just below the individuals at the top have worse health than those at the top, and so on down the social hierarchy. This not only means that the poor have worse health than the rich, but it also implies that the middle class have worse health than those who are more affluent. The CSDH asserts that this relationship holds for people in poor and rich countries alike, and that it even holds in better-off countries where living conditions among the poorest groups are far above any absolute poverty line.⁴⁵

Recommendations outlined in the report seek to reduce the slope of the social gradient, break the link between position in the social hierarchy and health outcomes, and improve the life opportunities and health status for those who are the worst off.⁴⁶ Some of the proposals overlap with the agenda of the human rights community. One CSDH strategy, for example, is to promote health status by making investments in early childhood development (defined as prenatal to eight years of age) and to promote access to education.⁴⁷ Other recommendations go beyond a human rights approach. For example, the CSDH maintains that the most effective way to promote greater equality in health status is to change the underlying causes of inequality — the social and political structures, policies, and mechanisms that shape the unfair and inequitable distribution of and access to power, wealth, and other necessary

resources.⁴⁸ A human rights approach usually focuses on more modest and incremental policy changes.

In contrast with the CSDH, a human rights approach rarely considers inequalities in economic status and social class to be problematic unless they interfere with the realization of human rights or are implicated in differential treatment by the state. This approach reflects a difference in perspective about the kinds of inequalities that matter, and what should be done about them. Human rights law is concerned with disparities in the enjoyment of rights rather than differentials in social position, access to resources, and political power. There are a variety of reasons why this is the case.

Perhaps foremost, the emphasis in the human rights paradigm is on equality of dignity, legal standing, and legal status, and not equality in social or economic position. A human rights approach is grounded in the affirmation that “[a]ll human beings are born free and equal in dignity and rights.”⁴⁹ Non-discrimination, together with equality before the law and equal protection of the law, constitute core human rights principles.⁵⁰ Discrimination “constitutes any distinction, exclusion, restriction or preference or other differential treatment that is directly or indirectly based on the prohibited grounds of discrimination and which has the intention or effect of mollifying or impairing the recognition, enjoyment, or exercise, on an equal footing of Covenant rights.”⁵¹ International human rights law requires that state parties implement the specific human rights enumerated in instruments that they have ratified without distinctions of any kind or preferences based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth, or other status.⁵²

To what extent can non-discrimination, equality before the law, and equal protection of the law, even if fully respected, bring about a more “equalitarian” society? Here it is helpful to cite Albie Sachs, an anti-apartheid activist and then member of South Africa’s Constitutional Court for 15 years. In his 2009 book, *The strange alchemy of life and law*, Sachs suggested that the equal protection principle is not sufficient to compensate for the status of disadvantaged persons who have been forced by racial discrimination to live in conditions of gross inequality, not even when paired with affirmative action. According to Sachs, equal protection coupled with affirmative action can

greatly assist the emerging new black middle class in South Africa, but not the desperately poor, because these principles do not require positive action on the part of the state to enable people to live in conditions consistent with at least minimum standards of human dignity.⁵³

Gillian MacNaughton’s recent analysis of equality and non-discrimination in international human rights law further illuminates the limitations of these concepts for addressing economic and social inequalities. In her 2009 article in this journal, she observes that, although equality and non-discrimination are separate principles, both legal scholars and UN treaty bodies have tended to conflate the two, thereby reducing their potential for addressing social inequalities.⁵⁴ She explains that interpretations of equality are usually stated in the negative form as non-discrimination, which prohibits differences in treatment upon a number of expressly prohibited grounds. In contrast, a positive interpretation of equality would require that everyone be treated in the same manner unless explicit justification is provided. Additionally, when legal scholars and courts describe relationships between equality and social rights they rarely acknowledge that poverty and economic status are prohibited grounds of discrimination under international human rights law.⁵⁵ Referring to the drafting history of the equality of law provision in the Universal Declaration of Human Rights and the International Covenant on Civil and Political Rights, MacNaughton suggests that the intention was to assure that the law would be applied in the same manner to all. That is, the equality provision was aimed at formal equality in the way laws are to be enforced; it was not meant to provide a guarantee of substantive equality or to address underlying inequalities in power and socio-economic and political status that preclude equal enjoyment of rights.⁵⁶

A related issue is the question: who is the subject of equality under international human rights law? That is, “who will be equal to whom?” MacNaughton distinguishes between simple or individual equality of all persons and bloc equality which requires equality between blocs or social groups, but not among individuals within the bloc. According to MacNaughton, international human rights law has focused primarily on bloc equality, often equating it with non-discrimination. There has been substantially less scholarly work and attention devoted to the subject of how

individual one-to-one equality applies with respect to economic and social rights.⁵⁷

Nevertheless, it should also be noted that the requirements of economic, social, and cultural rights have additional implications regarding social and economic inequalities. Many of the social determinants of health — access to health care, nutritious food, education, decent conditions of work, adequate housing, clean water, and adequate standard of living — are recognized as human rights conferring a moral obligation on all states. Additionally, those countries which are state parties to the ICESCR have a legal obligation to move progressively toward full realization of these rights to the maximum of their available resources.⁵⁸ To compensate for rights fulfillment being conditional on available resources, the CESCRC also specifies that every state party, regardless of available resources, ensure satisfaction of at least minimum essential levels of each right.⁵⁹ These minimum essential levels or core obligations as defined by the CESCRC Committee in relationship to individual rights, particularly the right to health, are quite extensive.⁶⁰ If states were to implement these core obligations, the status and well-being of poor and disadvantaged individuals and groups would be significantly improved. However, as Alicia Ely Yamin has proposed, even if converted into effective strategies, the provision of a minimum essential level of health care, housing, education, and the like would reduce absolute deprivation — whereas equality is a matter of relative deprivation.⁶¹

Like the CSDH, the human rights community historically has accorded priority to the status and needs of the most disadvantaged and vulnerable individuals and communities. Because a human right is a universal entitlement, its implementation is measured particularly by the degree to which it benefits those who hitherto have been the most disadvantaged and vulnerable and brings them up to mainstream standards.⁶² The CESCRC Committee stipulates that even in times of severe resources constraints, whatever the cause, the vulnerable member of society can and indeed must be protected — for example, by the adoption of relatively low-cost targeted programs.⁶³ Few countries, however, appear to take this prescription seriously.

In recent years the human rights community has also given greater attention to poverty as a human rights problem.⁶⁴ Some analysts working on health

and human rights issues recognize that the strong and pervasive links between poverty and health mean that a commitment to health necessarily implies a commitment to reducing poverty and its associated social disadvantages.⁶⁵ More generally, however, there is little conceptual clarity as to whether poverty or extreme poverty is a violation of human rights, a violation of one right (namely, the right to an adequate standard of living or a right development), or a cause or consequence of human rights violations.⁶⁶ Much of the work on poverty and human rights has addressed how to design, implement, and monitor a poverty reduction strategy through a human rights-based approach rather than assessing the impact of poverty on human rights.⁶⁷ Moreover, there has been little in-depth research on poverty and health from a human rights perspective.

If the human rights community wants to improve health status and health outcomes throughout the society, as well as to protect the interests of vulnerable and disadvantaged groups, it will need to pay more attention to differences in social, economic, and political status and their underlying causes and mechanisms. The health gradient and the associated disparities and inequities are significant issues that are far more than a simple problem of poverty or marginalization; rather, they affect all classes from the top to bottom of society. A *British Medical Journal* report in 2009 identified some 200 peer reviewed studies that associated income inequality with lower life expectancy, lower birth weight, higher rates of infant and child mortality, shorter height, poor self reported health, and vulnerability to AIDS, depression, mental illness, and obesity.⁶⁸ Data also indicate there is a continuous gradient in death rates: the higher people's status, the longer they live.⁶⁹ Moreover, data from a wide variety of sources reveal that health differences between classes have increased during the last few decades.⁷⁰ Such evidence suggests that the greater part of health inequalities would persist even if it were possible to eliminate all of the health problems associated with poverty and discrimination.

Peer-reviewed studies also conclude that more equal societies have better health.⁷¹ As long ago as 1996, the editor of the *British Medical Journal* wrote, "The big idea is that what matters in determining mortality and health in a society is less the overall wealth of that society and more how evenly wealth is distributed. The more equally wealth is distributed the better the health of that society."⁷² While the benefits of

greater equality extend to everyone, they tend to be greatest among the poor.⁷³ Moreover, more egalitarian societies tend to have greater social trust and ability to cooperate, and to be less violent and less likely to discriminate against vulnerable groups (whether women or religious, racial, or ethnic minorities), thereby offering a social environment conducive to promoting human rights.⁷⁴

So how might a rights-based approach to health incorporate a more sustained commitment to and promotion of substantive equality of health and social status? Gillian MacNaughton has proposed that principles of equality and non-discrimination might be more effectively employed for this purpose by recognizing poverty itself as a status, and one-to-one equality as a complement to social rights. A prohibition against discrimination on the basis of economic status might also help to secure a more equal distribution of financing for economic and social rights. In addition, MacNaughton observed that there is support for both of these approaches in the International Bill of Human Rights. For example, one-to-one equality is recognized in civil and political rights, in conjunction with such rights as the right to vote.⁷⁵ To translate one-to-one equality from political into social and economic rights, however, may first require building greater consensus in the human rights community as to what substantive equality entails — as, for example, in the field of health.

Power, money, and resources

One of the Commission's principles of action is the need to address the inequitable distributions of power, money, and resources in the way society is organized as, for example, the pervasive inequalities between men and women.⁷⁶ According to the Commission, inequities or avoidable inequalities in power interact across four main dimensions — political, economic, social, and cultural — and, together, they constitute a continuum along which groups are excluded or included to varying degrees. As conceptualized by the CSDH, the political dimension comprises formal rights embedded in legislation, constitutional provisions, policies, and the conditions under which rights are exercised — such as access to safe water, sanitation, shelter, health care, and education.⁷⁷ Strangely, however, it does not include the formal power structure of the society, the nature of the government, or the character of the major political actors. The economic dimension is constituted

by access to and distribution of material resources necessary to sustain life, and the social dimension by proximal relationships of support and solidarity, such as friendship, family, clan, community, and movements. Finally, the cultural dimension relates to the extent to which a diversity of values, norms, and ways of living with relevance for the health of all are accepted and respected.⁷⁸

The CSDH report has both a bottom-up and a top-down strategy for addressing power imbalances. Borrowing from a human rights approach — without clearly acknowledging such — the CSDH report looks to civil society actors as powerful drivers for positive social, political, and economic changes that affect health equity. As noted, its secretariat had argued for adoption of a human rights framework precisely because the human rights paradigm advocates for the empowerment of disadvantaged communities enabling them to exercise greater control over the factors that determine their health.⁷⁹ *Closing the gap* devotes one chapter to a discussion of “Inclusion and voice” as aspects of political empowerment, recognizing the importance of bottom-up approaches to health equity to complement its predominant focus on government-initiated policy changes.⁸⁰ The report also acknowledges that community or civil society action on health inequities cannot be separated from the responsibility of the state to guarantee a comprehensive set of rights and ensure the fair distribution of social goods.⁸¹

The CSDH report recognizes the importance of the power dimension; it is another issue, however, whether its analysis of power is sufficiently robust and its prescriptions likely to be adopted, and if so, effective. The bold statements in *Closing the gap*, addressing the need to change the power structure in order to promote health equity, are not translated into an agenda likely to accomplish that goal. Nevertheless, many of its recommendations related to power, resources, and money go well beyond those offered in human rights documents in their objectives and specificity. Believing that every aspect of government and the economy has the potential to affect health and health equity, the report puts forward an integrative approach to health equity across all areas of the government, and not just within the health sector.⁸² The CSDH advocates for a strong public sector that is committed, capable, and adequately financed to fund action across the social determinants of health. While human rights law is neutral on the issue of the priva-

tization of health and other social services, with the caveat that private provision not reduce the availability, accessibility, acceptability, and quality of health facilities, goods, and services, the CSDH argues that it is essential to have strong public sector leadership, public financing, and universal public health service provision to be able to make progress towards health equity.⁸³ This position is supported by health research showing that the privatization of health care services can have a negative effect on the accessibility of health care services to poor and disadvantaged people, particularly in poorer countries.⁸⁴ Similarly, while General Comment 14 stipulates that health facilities, goods, and services must be affordable for all, the Commission devotes an entire chapter on the importance of public financing through progressive taxation so as to provide adequate resources on an equitable basis to fund programs across the social determinants of health and universal health system services.⁸⁵

The CSDH's thesis, holding that efforts to promote greater health equity often require changes in the power structure of a society, is important to consider and often overlooked by the human rights community. Some human rights scholars and advocates are well aware that "health is a reflection of power relations as much as biological or behavioral factors."⁸⁶ Others document the role of "pathologies of power" in violating social and economic rights and creating patterns of ill health and disability.⁸⁷ And the empowerment dimensions of the human rights paradigm can be a significant catalyst for mobilizing participation and challenging political and other forms of exclusion. However, the human rights community often lacks sensitivity to the manner in which the top-down organization of power across the political, economic, and social systems affects the realization of human rights. All too often human rights actors identify policy changes needed to accomplish specific human rights goals and then rely primarily on exhortation for their implementation, or in the case of states which are clearly violating international standards, naming and shaming them. Human rights actors tend to attribute failures to follow human rights prescriptions to a lack of political will on the part of the government, rather than analyzing the underlying national and international power dynamics and structural determinants that block implementation.

More consistent attention to power dynamics would be an important complement to other human rights

modes of analysis. As Alicia Ely Yamin has observed, the way power is conceptualized in a rights framework is linked both to notions of participation and more fundamentally to how we understand the purpose and meaning of human rights themselves.⁸⁸ Structural analysis of the way that social, economic, and political structures of societies intersect with the fulfillment of rights would be an appropriate starting point. Researchers working on rights-based approaches to health could also draw upon the work being done on empowerment and participation.⁸⁹ Moreover, the human rights community would do well to invest greater effort to determine what kinds of political structures, institutions, and modes of financing are conducive to the fulfillment of specific social and economic rights.

CONCLUSION

This article has argued that realization of a right to health requires greater attention to the social determinants of health, health inequalities, and the realities of power dynamics. The article offers specific recommendations in each of its three main sections as to how it would be possible to move toward these objectives. More fundamentally, it suggests that the right to health incorporate more of the research, methodologies, and conceptual frameworks from the social medicine and social epidemiology fields into human rights investigations and research. Some human rights scholars, whose work is cited in the article, are already doing so. But what are the prospects for broader collaboration between the human rights and social medicine communities?

The article began by referring to Philip Alston's 2005 article, in which he portrayed the relationship between the human rights and development communities as two ships passing in the night, each with little awareness of the other or serious interest in interaction despite their common interests and the synergies between them. By drawing this comparison, Alston called upon the human rights community to engage more effectively with the development agenda, particularly with efforts to promote the MDGs.⁹⁰

The situation has improved since Alston's critique was published. Members of the human rights and development communities have begun to take greater cognizance of each other and found ways to collaborate beneficial to both, particularly in developing rights-based approaches to the Millennium Development Goals. Initiatives have come from both sides, but

more often from the human rights community. The UN Office of the High Commissioner for Human Rights (OHCHR) published a manual *Claiming the Millennium Development Goals: A human rights approach*, that invited the human rights community to claim the MDGs by harmonizing their targets and indicators with human rights standards, particularly with regard to economic, social, and cultural rights, and ensuring enforceable rights, accountability mechanisms, and sustainable strategies.⁹¹ The OHCHR also organized workshops in various regions on the topic. Human rights specialists have published thoughtful articles on integrating human rights into the MDGs.⁹² Human rights groups, including Amnesty International, have sought to generate interest among the international human rights community and some are working in coalitions seeking to influence the outcome of the 2010 MDG summit. The UNDP has published manuals on ways in which human rights are relevant to its programming.⁹³ The journal *Sur* dedicated its June 2010 issue to human rights and the MDGs.⁹⁴ Nevertheless, there is still a long way to go toward sustained cooperation on the development of a shared conceptual understanding.

Unfortunately, there do not seem to be institutional actors on the horizon ready to reprise the matchmaker roles of the OHCHR and the UNDP to promote greater collaboration between the human rights and social medicine communities. However, the small, but significant, body of work already reflecting a synthesis of the two fields is a hopeful sign of a growing interest in enriching human rights by incorporating the conceptual approaches of social medicine. The brutal inequalities in the world in which we live underscore the importance of doing so. Notably, the CSDH report opens with an eloquent appeal for social justice to close dramatic differences in health and life expectancy that are closely linked with degrees of social disadvantage. Reducing avoidable health inequalities and improving the life prospects of the poor and disadvantaged is literally a matter of life and death for millions of people. Thus, hopefully the shared commitment toward this goal of those working on the social determinants of health and on health and human rights issues will provide an incentive to greater cooperation. It will not be to the benefit of either to be two ships passing in the night.

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