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Missed opportunities: human rights and the Commission on Social Determinants of Health[1]

Paul Hunt

UN Special Rapporteur on the right to the highest attainable standard of health (2002–8)

All those responsible for 'Closing the gap in a generation' (1), the report of the Commission on Social Determinants of Health, deserve great credit for placing equity at the heart of the debate about health. This excellent report highlights vital issues that are often neglected. Others have emphasised the report's many strengths and virtues. I will not repeat, but firmly endorse, these richly deserved remarks. In this supportive context, I offer some constructive criticism of the report. My remarks aim to deepen and advance the report's analysis and recommendations.

'Closing the gap' is a human rights report, no less than a publication of Amnesty International, Human Rights Watch or the UN Human Rights Council. It exposes systemic inequality and discrimination on a global scale – and the struggle against inequality and discrimination lies at the heart of human rights.

One of the cardinal objectives of the United Nations – set out in the opening article of the UN Charter – is to promote and protect human rights without discrimination. Equality and non-discrimination are key elements of the Universal Declaration of Human Rights, the 60th anniversary of which we celebrate next month. The entire post-1945 international code of human rights rests upon the principles of equality and non-discrimination (2), and these issues form part of the report's fabric.

But the report is a human rights report in other ways, too.

The report is about poverty – and today it is recognised that poverty is a human rights issue (e.g. see Office of the UN High Commissioner for Human Rights (3,4)). Numerous human rights bear upon poverty: the rights to basic shelter, food, education and health-related services, as well as classic civil and political rights, such as freedoms of expression, assembly and association. The report is replete with other important human rights issues, the right to safe working conditions, the right to a safe environment and so on.

So, in an important sense, 'Closing the gap' is a human rights report. And yet, strangely, it isn't!

Despite the multiple, dense connections between social determinants and human rights, the report's human rights content is disappointingly muted. The human rights analysis is not absent, but underdeveloped and understated.

The last 10 years have witnessed some remarkable changes in our understanding of human rights and health but, with honourable exceptions, the

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health professions remain largely unfamiliar with these important developments. When discussing human rights it is as though they are consulting a very early edition of a textbook that is now almost entirely out of date.

After their historic inclusion in the objectives of the United Nations, international human rights were set out in the Universal Declaration of Human Rights (1948) and thereafter in a battery of international human rights instruments. Many of these are binding international human rights treaties, such as the Convention on the Rights of the Child. They encompass civil, political, economic, social and cultural rights, and some also include the right to development.

Until about 1990, however, the UN's human rights focus was on civil and political rights, such as the prohibition against torture, the right to a fair trial and freedom of expression. With the fall of the Berlin Wall, this began to shift. In the 1990s, the UN began to give more serious attention to economic, social and cultural rights, such as the rights to education, shelter, food and the highest attainable standard of health.

Something else very significant also happened at this time. In 1997, Secretary-General Kofi Annan proposed a bundle of UN reforms including the proposal that all human rights – not just civil and political rights – should be integrated throughout the world organisation (5). The UN General Assembly adopted these reforms including this far-reaching human rights proposal. As 'Closing the gap' tends to testify, specialised agencies and other UN bodies are still struggling to implement Kofi Annan's human rights vision for the United Nations.

I will briefly look at one economic, social and cultural right, the right to the highest attainable standard of health (or 'right to health'),[2] because it has special relevance to the Commission's report.

The foundations for this fundamental human right are in the Universal Declaration of Human Rights. The right is in the major legally binding international human rights treaties that countries have drafted and chosen to sign up to. It is part of what is known as the International Bill of Rights.

Until 2000, however, it was not clear what the right to the highest attainable standard of health meant. In that year, a group of international experts agreed a document, called General Comment 14, which sets out in some detail what is understood by this human right (6). These experts were chosen by governments but, once appointed, were independent. They drew upon international human rights, as well as good health practices. They benefited from the expertise of the World Health Organization and civil society organisations. The right to health provisions of most international treaties are only a few sentences, whereas General Comment 14 has 65 paragraphs. It transformed the right to the highest attainable standard of health from a slogan to something that can make a constructive, concise contribution to health-related policies, programmes and practices.

What does this human right consist of? Time permits only a few remarks. Briefly, it encompasses medical care, as well as access to safe water, adequate sanitation, a safe working environment, access to health-related information and education and other critical pre-conditions of good health (6). Moreover, it places an obligation on governments to address discrimination and inequality. The right to the highest attainable standard of health requires governments to enhance access for disadvantaged individuals, communities and populations; in other words, it has a social justice component. It also requires governments to put in place arrangements that facilitate the active and informed participation of those affected by health-related policies, programmes and practices. Crucially, the right to the highest attainable standard of health is subject to progressive realisation, i.e., no government is expected to realise it overnight – or even in 10 years – but to progressively work towards its realisation. This means we need indicators and benchmarks to measure whether or not progress is being made. However, the right to health is subject to resource availability, in other words, more is demanded of Canada than Chad. Monitoring and accountability are crucial elements of the right to the highest attainable standard of health. Too often today, the same body is responsible for delivering and regulating health-related services, as well as holding those responsible to account; from the right to health perspective, this is problematic. At the core of the right to health is an equitable, integrated, responsive, effective health system that is accessible to all and of good quality (7).

This human right is not just the preserve of international human rights systems. It is enshrined in the

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WHO Constitution, Declaration of Alma-Ata, Ottawa Charter for Health Promotion and other important documents agreed by the health community.

Over the last six years, the UN General Assembly and UN Commission (now Council) of Human Rights has routinely received reports on numerous aspects of the right to health, including water and sanitation, the Millennium Development Goals, maternal mortality, the skills drain, access to medicines, the right to health responsibilities of pharmaceutical companies and so on.[3]

The Department of Health of England recently commissioned an assessment of the effectiveness of implementing a human rights-based approach in health and social care. Focusing on five pilot projects, the assessment concluded that such an approach had a noticeable effect on the treatment and care of health service users, and that it was one way of achieving good practice (8). Uganda is reviewing its health policies through the right to health lens (9). Increasingly, non-governmental organisations are using the right to health analysis in their reports and campaigns (e.g. see Physicians for Human Rights (10)). In 2009, Amnesty International is due to launch a global campaign on maternal mortality as a human rights issue.

Numerous constitutions and other national laws include the right to the highest attainable standard of health (11). Of course, some of these provisions are little more than adornments. But some are not. Some are giving rise to important cases that are leading to improvements in health-related services. While the South African cases are the most well known,[4] Latin American countries have generated an especially large number of right to health cases (e.g. see Hogerzeil et al. (12)). Most recently, the Colombian Constitutional Court ordered a phased restructuring of the country's health system by way of a participatory and transparent process based on current epidemiological information. The Court's decision relies upon the right to health (13).

This survey is not remotely comprehensive but it is sufficient to make the point that the right to the highest attainable standard of health, as well as other health-related rights, are now being taken seriously at the international, national and local levels. Hence my surprise and disappointment that the Commission's report does not devote more space to human rights, especially when the links between social determinants and human rights are so clear and profound.

As the independent UN Special Rapporteur on the right to the highest attainable standard of health (2002–8), I advised governments and others on how to implement the right to health. My first report explained that I would give particular attention to two social determinants: poverty and discrimination (14). Thus, these themes recur throughout some 30 reports submitted to the UN General Assembly and UN Commission (now Council) of Human Rights. My right to health report on Peru, for example, advocates and outlines a 'pro-poor, equity-based health policy'. More specifically, it considers: unsanitary housing, the health of indigenous peoples and unsafe mining practices that are damaging the health of rural and urban communities (15).

In summary, there can be no doubt that the right to the highest attainable standard of health encompasses social determinants. This fundamental human right places legal obligations on governments to tackle social determinants where they harm health. 'Closing the gap' correctly argues that addressing harmful social determinants is an ethical imperative. But it is more than that. Addressing harmful social determinants is also a legal imperative. Reinforced by law, human rights are equity and ethics with teeth.

Unfortunately, the right to the highest attainable standard of health remains much misunderstood. Some say it is only aspirational, but this is simply untrue. The right to health provisions of the Convention on the Rights of the Child place legally binding obligations on all those governments that have chosen to ratify this treaty, namely all governments in the world except Somalia and the United States of America.

Some say the right to health is unrealistic. Not so. Rooted in reality, the right to health is subject to progressive realisation and resource availability, concepts that place obligations on governments while recognising some things take time and that some countries are richer than others.

Some say the right to health is radical. The right to health, which gives rise to a responsibility to establish an equitable health system, is no more radical than the right to a fair trial and the corresponding responsibility to establish a fair court system. Whether radical or not, countries have repeatedly

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reaffirmed that the right to health is part of international law and numerous countries around the world have placed it in their constitutions.

Some say the right to health is confrontational or adversarial. It certainly confronts inequality, discrimination and social injustice. But it is not just about going to court, it is also a way of shaping health-related policies, programmes and projects so they are robust, sustainable, effective and meaningful to the disadvantaged.

As the UN and many others have devoted more attention to the right to health over the last 10 years, new human rights tools and techniques have been developed. We no longer only think in terms of taking test cases in the courts, letter-writing campaigns and 'naming and shaming' – although these continue to have an important role to play. Additionally, we use indicators, benchmarks, impact assessments, budgetary analysis, and so on (7). Accountability is now understood to be much broader, and more subtle, than judicial accountability, which is accountability of last resort. As recently explored by Helen Potts, there are other forms of accountability, such as national human rights institutions, public enquiries, local health councils, regional health conferences with grassroots participation, maternal death audits or reviews and so on (16). Human rights accountability is not just about blame, sanction and punishment. It is about finding out what works, so it can be repeated, and what does not, so it can be revised – what Lynn Freedman calls 'constructive accountability' (17).

In short, the focus of human rights has changed in recent years. They are no longer only about civil and political rights they are also about economic, social and cultural rights. They are not just about 'naming and shaming', they are also about indicators, benchmarks, impact assessments, budgetary analysis and 'constructive accountability'.

For their part, human rights workers must do more to familiarise themselves with health issues, including social determinants. The UN human rights machinery should be encouraged to devote more time to the vital issues raised by 'Closing the gap'. This impressive report should go to the UN Human Rights Council and UN treaty-bodies such as the Committee on the Rights of the Child, Committee on Economic, Social and Cultural Rights and Human Rights Committee. The UN human rights system can help to hold governments accountable in relation to the report's findings; for example, when appearing before the independent human rights treaty-bodies, governments can be asked what they are doing to implement the report's recommendations.

Since 2000 the US administration has been hostile to the right to the highest attainable standard of health. This opposition has manifested itself in numerous ways. Only two countries, for example, voted against the Brazilian proposal to appoint a UN Special Rapporteur on the right to the highest attainable standard of health: USA and Australia (under the premiership of John Howard). Because of Washington's power and influence, US opposition to the right to the highest attainable standard of health has had a deeply chilling effect, making it difficult for UN bodies, initiatives and reports to discuss right to health issues in an open, balanced, rational and constructive manner. It is extremely important that the new US administration adopts a more benign approach to this life-and-death feature of the International Bill of Rights. The administration does not have to champion the right to health, but simply allow others to vigorously explore its contours, content, implications and practical application, as befits a fundamental human right.

The human rights approach is entirely consistent with the analysis and agenda set out in 'Closing the gap' and, for that matter, the recent WHO World Report 2008 on primary health care (18). The human rights approach is not something apart, or separate, from the movements for social determinants, primary health care, health equity, continuum of care and so on. It is not an alternative approach. Rather, with its insistence on transparency, participation, equitable access, monitoring, accountability and so on, it fortifies and reinforces these other approaches. It brings a compelling frame of analysis and heightens political and moral urgency. Crucially, it introduces legal obligation, enabling reformers to say to ministers and officials – not only is a suitable policy a matter of good practice, it is also required by law. Just as they advise ministers to comply with environmental and planning law, officials also have a responsibility to advise governments to comply with binding international and national human rights law.

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Despite its great value, the Commission's report represents a series of missed opportunities. There are misunderstandings about the right to the highest attainable standard of health that are highly relevant to social determinants and here was a chance to puncture them. In the context of social determinants, the report could have done more to emphasise the common ground between medicine, public health and human rights. It could have set out General Comment 14 and explained that the right to health is partly about participatory, transparent, non-discriminatory processes striking fair balances that are respectful of the entitlements of the most disadvantaged, including those living in poverty. It could have outlined that human rights do not prevent society from taking, in exceptional cases, coercive measures, including quarantine, provided that some critically important and reasonable safeguards are in place. After briefly disposing of some of the common misconceptions about human rights, the way would then have been clear for a concise well-informed explanation of how contemporary human rights are a powerful ally in the struggle against harmful social determinants. The report could have explained that recognising social determinants as a human rights issue does not mean that an under-achiever, like Vicky Pollard, can take the Government to court because she failed to pass a minimum number of examinations. What human rights mean is that the authorities must be held to account and required to explain, before an appropriate independent body (not necessarily a court of law), that they are doing all they reasonably can to ensure that the disadvantage experienced by individuals, communities and populations is being tackled as a matter of urgency. Moreover, if the independent body finds that the authorities have not done all they reasonably can, it can require redress. Redress comes in many forms, including full and public disclosure; acceptance of responsibility; re-affirmation of objectives and obligations; revised policies, programmes, projects and plans, with timeframes, indicators, benchmarks and budgets; better monitoring; and so on (17). Just as accountability is not only about judicial accountability, redress is not only about monetary compensation.

In conclusion, 'Closing the gap' could have briefly explained that while human rights do not provide neat answers to complex policy problems, any more than do ethics or economics (or any other body of thought), they have greatly matured in recent years and are now a potent tool that can help deepen the report's analysis and achieve its recommendations.

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Notes

1. This Address was presented at the conference 'Closing the gap in a generation: health equity through action on the social determinants of health', 6–7 November 2008, London.
2. The full name of this human right is the right of everyone to the enjoyment of the highest attainable standard of physical and mental health see, for example, article 12 International Covenant on Economic, Social and Cultural Rights.
3. These can be accessed via the websites of (a) Office of the UN High Commissioner for Human Rights and (b) Right to Health Unit, Human Rights Centre, University of Essex. Available from: http://www2.essex.ac.uk/human_rights_centre/rth/
4. Such as *Minister of Health v Treatment Action Campaign*, CCT 8/02.

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