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REALIZING HUMAN RIGHTS-BASED APPROACHES FOR ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

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ABSTRACT

Health inequities are clear evidence of violations of the right to health. Yet despite this common ground, action on the social determinants of health aiming to reduce health inequities is sometimes disconnected from implementation of human rights-based approaches. This is explained in part by differing histories, disciplines, and epistemologies. The capacity of human rights instruments to alter policies on social determinants can seem limited. An absolutist focus on individuals and processes can seem at odds with the attention to differences in population health outcomes central to the concern for health equity. However, developments in rights-based approaches have seen the terrain of human rights increasingly address social determinants. Human rights provide a firm legal basis for tackling the inequities in power and resources that the Commission on Social Determinants of Health identifies as fundamental to achieving health equity. Indicators and benchmarks developed for rights-based approaches to health systems can be developed further within health sectors and translated to other sectors and disciplines. The discourse and evidence base of social determinants can also contribute to implementing rights-based approaches, as its resultant policy momentum can provide essential levers to realize the right to health. Therefore, there is no clear-cut delineation between the human rights and health equity movements, and both may constructively work together to realize their goals. Such constructive collaboration will not prove straightforward; it will, instead, require profound engagement and innovations in both theory and practice. Yet this effort represents an important opportunity for those who seek social justice in health.

INTRODUCTION

Speaking at an international conference held in London to mark the launch of the final report of the WHO Commission on Social Determinants of Health (CSDH), Paul Hunt, then the United Nations Special Rapporteur for the Right to Health, argued that

[d]espite 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. . . . Despite its great value, the Commission's report represents a series of missed opportunities.¹

At first glance Hunt's critique of the CSDH's final report seems surprising. The report is infused with references to "rights" and places the attainment of health equity as a moral imperative. The report also identifies the importance of rights-based approaches for reducing health inequities. In arguing for Hunt's role to be made permanent, the report stated:

There are clear links between a 'rights' approach to health and the social determinants of health approach to health

equity. The Universal Declaration of Human Rights points to the interdependence of civil, cultural, economic, political, and social rights — dimensions of social exclusion highlighted in the social determinants of health framework. 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.²

The case for health equity, distilled in the diagnosis and recommendations of the CSDH's final report, shares much in common with the drive to realize human rights.³ In terms of values, both present moral arguments whereby the ends — health equity or human rights — are often seen as goods in themselves. Both are conceived in terms of fulfilling justice, in particular, social justice. The Commission's vision to “close the gap in a generation” strongly affirms the right to health as it is articulated in the World Health Organization (WHO) Constitution, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights (ICESCR), and the Alma-Ata Declaration.⁴ Advocates of action on the social determinants to reduce health inequities have close links to those who promote realizing the right to the highest attainable standard of health (“the right to health”) and other so-called “positive” rights. Countries such as Brazil, that have been at the forefront of global work on the social determinants, have argued for the importance of the right to health in international fora and have seen rights-based approaches actively promoted to improve participation and address inequities within their own national contexts.⁵ The Commission's damning conclusion, that “social injustice is killing people on a grand scale,” which therefore demands action on the social determinants of health, corresponds to claims that human rights provide “the necessary means to create conditions that enable people to achieve optimum health” and that by “seeing health as a right, we acknowledge the need for a strong social commitment to good health.”⁶

Why then, did Hunt find the CSDH's final report disappointing? His central critique is that the Commission, while subscribing to the importance of human rights, has not recognized the advances made around the right to health and other human rights in the last decade, nor has it fully grasped the potential of rights-based approaches to contribute to achieving

health equity. Furthermore, Hunt suggests that the Commission missed the opportunity to advocate the use of rights-based approaches by clarifying common misconceptions around their use. His subtext seems to suggest that the Commission could have made an important contribution to remedy the underutilization of human rights to improve health and health equity.

In fact, Hunt himself and other human rights colleagues, including the human rights team at WHO, made a significant imprint on the work of the CSDH. But, perhaps, it was not enough. Hunt's misgivings about the CSDH's final report suggest a surprising problem that has been confirmed by our experience working as part of the WHO Secretariat of the CSDH (and as we now work to facilitate the implementation of its recommendations). Despite the axiomatic, discursive, and rhetorical convergence between human rights and health equity, there does not appear to be an easy fit, in practice, between those who are working to enact policies to address the social determinants and those implementing human rights-based approaches. In this paper, we consider possible explanations for this dysjuncture, looking at differences in values, paradigms, and histories. We then discuss why making better use of rights-based approaches is important for action on social determinants. Finally, we reflect on why the human rights community might wish to contribute to work on health equity, and the key challenges that need resolution for this to occur.

OBSTACLES TO THE USE OF RIGHTS-BASED APPROACHES BY THE HEALTH EQUITY MOVEMENT

The last two decades have seen rapid advances in knowledge around health inequities, that is, avoidable, remediable, and unfair differences in health status between different populations, both within and between countries.⁷ The field of social epidemiology has focused on identifying and describing disparities in health outcomes according to a multitude of factors, such as ethnicity, education, gender, socioeconomic status, and place of residence. These efforts have included both documentation of the ubiquitous presence of these disparities and, increasingly, drawing attention to their causes.⁸ Building on social medicine and public health traditions, researchers have demonstrated that health is produced and destroyed across all sectors of society. Therefore, reducing health inequities requires action not just through health care services, but also at the level of changing

the social determinants of health — people’s daily living conditions and their access to power, money, and resources.⁹ The CSDH’s final report reviewed the increasing evidence of health inequities, and presented a range of recommendations to reduce health inequities, across the whole of society. The report also called for a global movement to achieve health equity.

General Comment 14 of the United Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR) interprets the right to health as “extending not only to timely and appropriate health care but also to the underlying determinants of health.”¹⁰ Given this international legal basis for action on the social determinants, it might seem likely that those implementing action on health inequities would make wide use of rights-based approaches. As above, the CSDH’s final report makes ample reference to the right to health and to General Comment 14.

And yet, discussions and policies aimed at reducing health inequities through action on the social determinants often omit a consideration of operationalizing the right to health, or using its legal frameworks. Those countries that have national strategies to reduce health inequities rarely invoke human rights instruments as key methods to implement or monitor policy. The right to health is often recognized as a powerful reason for addressing disparities, but appreciation of the advances in rights-based approaches that can be applied in policy seems limited. Even as strong an advocate for rights-based approaches as the legal scholar, Lawrence Gostin, sometimes neglects the use of human rights as more than a rationale for reducing inequities. In his recent call for a “global plan for justice” to eliminate the gross health inequities seen between countries, there is no mention of the use of human rights instruments for implementation.¹¹ The engagement of the health equity movement with the practical application of rights-based approaches is often no better than their poor uptake by health professionals in general — which has been identified as a major obstacle to progress on realizing the right to health.¹²

There are several possible reasons why the health equity movement does not make better use of rights-based approaches. First, while those advocating action on the social determinants often mount a strong critique of mainstream public health policy and practice, they draw from its traditions. Moreover,

both social determinants and health equity discourse use the same basic science as public health — epidemiology. Social epidemiologists have widened its scope, but they have maintained its methodology of studying populations to identify differential exposures that lead to differences in health outcomes. The “new public health” has broadened these exposures from traditional risk factors to systemic aspects of society, such as the distribution of power and the availability of resources.¹³ Health economists have also made significant contributions, particularly in evaluating inequities in coverage of health and other social services. Yet the main approach has still been to identify the causes of differences and develop population and individual approaches and interventions to remedy these disparities.

The Commission’s *Conceptual Framework for Action* — which itself draws on several other frameworks — clearly illustrates this perspective.¹⁴ The framework provides an explanation for how health inequities are generated and highlights entry points for actions to reduce these inequities. Identifying that populations have differences in terms of “structural” inequities (such as differences in socioeconomic status and education), harmful exposures, vulnerabilities, access to care, and the consequences of becoming sick, it provides a basis for the formulation of policies and interventions. The CSDH’s final report concludes that these differences are unfair — “the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics” — and therefore argues for action on health inequities as a moral imperative, independent of other considerations.¹⁵ However, country strategies for reducing inequities have generally been unable to free themselves from the need to engage in the policy “market,” with the resource constraints and political bargaining that this entails. While the final report of the CSDH does not provide a comprehensive account of how these trade-offs can be managed, it does engage traditional scientific problem-solving in public health by drawing on the framework to consider causes and “evidence-based” policymaking processes.

The human rights movement, and those implementing rights-based approaches, differ sharply from traditional public health practice in history, discipline, and epistemology. As Sofia Gruskin and colleagues have noted, public health and human rights have “evolved along parallel but distinctly separate tracks.”¹⁶ Human

rights discourse was shaped by the aftermath of the Second World War and the recognition of the need for strengthened protection of individual freedoms. Human rights practice has been dominated by the disciplines and principles of law applied to a focus on civil and political rights. Perhaps as a result, the focus has been on rights of “conduct” or processes rather than on health or social outcomes. This focus has highlighted the relationship between individual rights-holders and duty-bearers, drawing attention to violations of these duties and the potential for enforcement by reporting and legal remedy.

The right to health does not confer any right to a particular level of health for any particular population; rather, the focus is on the opportunities and processes that construct health. It might be argued that right-based approaches that employ a situation analysis broaden this approach.¹⁷ Such an analysis assesses context and who is affected, particularly in terms of human rights; undertakes a causal analysis of rights violations; identifies duty-bearers and their obligations; and evaluates the capacity development required to best enable the claiming of rights and fulfillment of duties.

Nevertheless, significant differences remain between a rights-based approach to health and many other health policymaking processes. Instead of concern for balancing interests in diverse populations, the rights-based approach often appears absolutist in terms of individuals — a right can be judged as either realized or not, notwithstanding the allowance for progressive realization of rights by countries when resource constraints apply.¹⁸ The recent adoption by the United Nations of the Declaration on the Rights of Indigenous Peoples is evidence, for example, of some progress in recognizing collective rights (discussed further below), but its lack of international legal force and application by those countries that have signed it reflects the continuing challenges that collective rights pose to rights-based approaches.¹⁹

This range of differences between the histories and practices of human rights and public health underpin many of the challenges for the health equity movement in making better practical use of rights-based approaches. Given the problem of health inequities as a moral challenge, policy makers aiming to reduce health inequities often struggle to see the value and relevance of making better practical use of human rights. Health inequities can seem to exert sufficient

moral force to impel action. Policy makers in countries are increasingly convinced that health inequities are a problem that demands attention (as seen, for example, by the passing of a resolution calling for action at the WHO World Health Assembly following the CSDH’s final report), but they also ask how this can be achieved in practice.²⁰

There is sometimes skepticism in the broader public health community concerning the added value of human rights. Some ask, with some justification, of the effectiveness of rights-based approaches to reduce health inequities given that many of the so-called “negative” rights, much more widely accepted, remain far from universal fulfillment. The capacity of international law and human rights instruments to alter government policies on social determinants can appear limited.²¹ Furthermore, there is no consistent correlation between the ratification of human rights treaties and improved health or social outcomes.²² Many would also agree with the contention of Asha George and colleagues that

[a]lthough important, a major limitation of the reliance on legal measures and abstract principles is that these in themselves provide scant guidance for real-world decision-making around resource allocation or programme strategies. . . .²³

The charge of over-reliance on legal measures is partially accepted by even human rights advocates. Alicia Ely Yamin, for example, in reflecting on how better to apply a human rights framework to health, suggests that the human rights community will need

to leave [its] comfort zone of clean hands and pure principles. [It] will need to roll up [its] sleeves and engage with processes of budgetary priority-setting and systems analysis, in order to be able to discern where problems lie — not only to assign respective responsibility, but also to propose solutions.²⁴

The health equity movement faces similar questions of practical applicability from other public health practitioners when advocating for action on the social determinants. Still, the focus on individuals and processes, as opposed to populations and health outcomes, also pose theoretical challenges to the

health equity movement understanding the utility of rights-based approaches. The confusion of the right to health with a right to health care, allied to greater progress in using rights-based approaches to secure fairer distribution of medical treatment, provokes further hesitation in a movement which is struggling to widen the lens of health policy beyond the health care sector.

Hunt argues that advancements in rights-based approaches over the last decade render many of these criticisms moot.²⁵ Ratification of human rights treaties is only the beginning of a rights-based process and the implementation, monitoring and reporting of actions mandated by these treaties is where positive health and social outcomes occur.²⁶ Despite the terse formulations of human rights covenants, increasing nuance in interpretation allows rights-based approaches to transcend many of the criticisms of human rights as overly focused on process or on civil and political rights. In doing so, greater attention has been brought to negative health outcomes, and the terrain of human rights increasingly intersects with the social determinants of health. For example, successive clarifications on the right to health have moved from the formulation in the International Covenant on Economic, Cultural and Social Rights, which considers physical and mental health but fails to consider social well-being, to the detailed clarification in General Comment 14, that the right to health encompasses social determinants.

Furthermore, there is no clear-cut delineation between the human rights and health equity movements. There are some in the health equity movement, particularly in activist and civil society groups, who see rights-based approaches as the primary vehicle to reduce health inequities.²⁷ At the same time, there are others who worry that rights-based approaches can have unintended negative consequences for health equity.²⁸ It is therefore worthwhile to consider more deeply how rights-based approaches can contribute to action on the social determinants.

THE CONTRIBUTION OF RIGHTS-BASED APPROACHES TO IMPLEMENTING ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

To say that rights-based approaches can contribute to action to reduce health inequities poses the question of what ends are being sought. It may appear controversial to view rights-based approaches as a tool. For

many in the human rights community, the realization of human rights is the end in itself. In the same way, the CSDH's final report argues for reduction in health inequities as a moral imperative. To us, even if we allow that human rights and health equity have intrinsic value, it seems likely that their primary benefit lies in facilitating the freedom and expression of people to pursue lives that they desire. Applied to health, this reflects the Ottawa Charter for Health Promotion's conception of health as "a resource for everyday life, not the objective of living," and Amartya Sen's view of development as freedom.²⁹

Despite these philosophical considerations, the goals of health equity and human rights advocates are primarily aimed at their respective main agendas. Therefore, in considering how rights-based approaches can contribute to work on reducing health inequities, we do not mean to assert that health equity is more important than human rights. Rather, reflecting our professional priorities, we seek to understand how a rights-based approach can explicitly incorporate equity as a fundamental norm to motivate action on the social determinants of health.

The CSDH's final report offers an extensive prescription of what is required across different sectors and at global, national, and local levels. In considering implementation of these recommendations, the subsequent work of WHO on social determinants of health and health equity has identified three broad themes: 1) reorientation of the health sector to address inequities, aligned to the renewal of primary health care; 2) work across sectors to consider health equity impacts and address social determinants; and 3) measurement and monitoring of inequities in social determinants and health outcomes, and the equity impacts of policies and programs.³⁰ Rights-based approaches can contribute much to each of these streams of implementation, and more broadly to the social change required to achieve health equity.

First, the importance of the moral and legal force of human rights recognized in international law cannot be underestimated. While there is broad agreement that health inequities are unjust, the existence of the right to health, in both national and international agreements, strengthens the diagnosis of injustice of differences in health outcomes due to social and political factors.³¹ Rights-based approaches establish a duty of governments to act according to principles of participation, equality, non-discrimination, and

accountability. They also establish the right of citizens to demand that states act in this manner. This establishment of duty and right provides a legal basis for tackling the inequities in power and resources that the CSDH report identifies as fundamental to achieving health equity. The right to health establishes a right to the social determinants necessary for health, and other economic and social rights (such as the right to food, the right to education, and the right to water) assert duties of provision of key social determinants.

The importance of this is perhaps best recognized and utilized by social movements and civil society groups.³² Activist campaigns based on rights-based approaches have remedied inequitable access to treatment. This has occurred most famously in the case of antiretroviral therapy for HIV/AIDS.³³ Particularly in Latin America, constitutional recognition of the right to health has successfully served as the basis for legal action to secure access to essential medicines.³⁴ These cases implicitly address how the provision of healthcare and the health sector itself is socially determined. Other legal cases, often also in Latin America, have challenged practices that undermine environmental determinants.³⁵ Some countries have “right-to-health” campaigns, whereby health inequities are used as key evidence for violations of the right to health, and where action on the social determinants is demanded.

Exploiting rights-based approaches also provides the potential to use the United Nations human rights system for the consideration of health equity. The Commission was keen to see health equity taken up in the United Nations. Current reporting mechanisms by countries to UN human rights institutions already provide some opportunity for the consideration of health equity issues. These proceedings have the potential to influence countries to accelerate progress on implementing strategies to address social determinants, as well as to provide an avenue for redress for individuals and communities who are affected by health inequities.

At best, legal instruments offer a partial solution to health inequities. Even as the violation of individual rights contributes to health inequities, not all health inequities can be explained by rights violations. For example, the social gradient identifies inequities even between relatively advantaged groups for whom most human rights are broadly fulfilled, as seen in

Michael Marmot’s seminal Whitehall studies (even allowing that in these cases the result was that the right to the highest attainable standard of health was unrealized).³⁶ Furthermore, legal remedies can also risk entrenching health inequities. Given the financial and social barriers to accessing legal systems, better-off communities may have greater ability to seek redress of the violations of their rights. Selective application of legal remedies may also result in distortions that undermine health equity.³⁷ For example, the vaunted success of legal actions to secure access to antiretroviral therapy has also brought criticism of prioritizing individual care over other health needs and action on the social determinants. Courts have also been accused of being blind to national resource limitations, thereby undermining the ability of governments to construct coherent and equitable health policy to address population health needs.³⁸

Fortunately, rights-based approaches can offer more than moral force or the capacity for legal enforcement. Hunt claims that the human rights community has begun to rise to Yamin’s challenge, noted above; rights-based approaches to health now encompass Hunt’s call for “indicators, benchmarks, impact assessments, budgetary analysis” and other measures.³⁹ Given state obligations to respect, protect, and fulfill human rights, Hunt also argues that governments can be held to account — and not only through legal means — if they cannot demonstrate they are doing as much as possible to prevent health inequities. Recent assessments of the performance of health systems in realizing the right to health substantiate how rights-based approaches can transcend legal instruments.⁴⁰ More evidence is required on how the use of such approaches improves health and health equity outcomes in health systems to increase its application by policy makers.

Advances in the development of indicators, as well as monitoring mechanisms that can be used at ground level, are essential for both human rights and social determinants approaches to make progress. Rights-based approaches can support both measurement of health inequities and disaggregation of data, by supporting the right of disadvantaged groups to be counted. Identifying whether claims to human rights have been fulfilled, or whether states are discharging their obligations appropriately, requires not only disaggregation of data but also the development of indicators for the implementation of poli-

cies and monitoring their impact. Here, rights-based approaches face similar demands and challenges as policy makers executing policy to address the social determinants. Indicators and benchmarks for rights-based approaches to health systems need to be developed further within health sectors and translated to other sectors and disciplines essential for health equity.

Rights-based approaches can also support the facilitation of participation in policymaking and governance. The health equity movement sees participation as essential to the social mobilization necessary for reducing health inequities. Participation is a core principle of rights-based approaches, and significant development has occurred in considering how to implement this principle and facilitate the empowerment of those affected by human rights violations to press their claims. Public health policymaking has sometimes paid lip service to the importance of participation, and there is the danger for strategies to reduce health inequities to become overly “top-down,” endangering success. Rights-based approaches can therefore make a significant contribution to ensuring that “top-down” policy is complemented by “bottom-up” social mobilization to generate the desired social change.⁴¹

The absolutism of human rights is a major challenge to overcome in order to harness the potential of rights-based approaches that can catalyze broad policy responses to address health inequities. The concept of progressive realization allows that rights can be realized over time in situations of resource constraints. However, it seems to be silent on how resources should be allocated to different rights. Action on social determinants requires a holistic response, balancing differing policies and developing better processes to make trade-offs, given available resources, in favor of improving social and health equity.⁴²

Rights-based approaches require greater sensitivity to these challenges to contribute further to policy decisions. It is important to challenge assumptions of scarcity, particularly when it is likely that the resources are available to fulfill all rights if allocated fairly on a global basis. However, policy makers in low- and middle-income countries increasingly are asking for interventions to reduce inequities that are feasible given their realities. The health equity move-

ment needs to navigate these competing imperatives. For rights-based approaches to address social determinants, a similar dilemma must be resolved.

One promising avenue to make progress on this challenge of addressing rights holistically is that found in recent work on the right to development. Ashley Fox and Benjamin Mason Meier have suggested that the right to health is constrained by its individual focus and not sufficiently robust to motivate action on the social determinants, despite General Comment 14.⁴³ They consequently argue for more attention to a collective right to development, which can act as a vector for a range of human rights, such as those to food, water, and health. This could validate the provision of public goods, such as key social determinants, that are undervalued by an individual approach.

Arguing for such collective rights is currently a vanguard position, with little institutional support as yet. However, such an approach seems to align better with the social determinants paradigm, with claims generated by differences between groups as opposed to the experiences of individuals. This would also address a potential criticism of the health equity movement: that it is unclear for which particular individuals action is being advocated. Fox and Meier also suggested that recognition of a collective right to development would facilitate more robust obligations of high-income countries to low- and middle-income countries, and reform of the constitutions of international bodies to facilitate this. Substantial progress on global health inequities is unlikely without such mechanisms to facilitate progress on fairer allocation of global resources.

REALIZING MUTUAL OPPORTUNITIES TO REALIZE THE RIGHT TO HEALTH AND REDUCE HEALTH INEQUITIES

In this paper, we have argued that rights-based approaches have much to contribute to reducing health inequities through action on the social determinants of health. There is some merit to Paul Hunt’s critique that the potential of rights-based approaches is not fully tapped in discourse and policies aimed at reducing health inequities. The intersecting health equity and human rights movements can constructively work together to realize the potential of rights-based instruments, such as legal mechanisms, indicators, and accountability frameworks, in addressing the social determinants of health. However, given

the differences between these approaches in, for example, their histories, disciplines, and epistemologies, effective collaboration will not prove a straightforward task. It will instead require profound engagement and innovations in both theory and practice. Clearly more remains to be done, even in conceptual terms, to fully realize the potential of rights-based approaches to reduce health inequities. And yet, this is not to underestimate the commonalities between the two approaches and their constituencies. There is ample scope to move from our discussion of the challenges in harmonizing rights-based and social determinants approaches to implementation and documentation of work in countries in a manner that effectively achieves the elusive goal of reducing health inequities.

Given the publication of this essay in a human rights journal, albeit in an issue devoted to the theme of social determinants, it seems reasonable to ask whether the human rights community is interested in making use of the social determinants discourse. Many speak of the importance of both the right to health and addressing social determinants, and some advocates of rights-based approaches are also champions for action on the social determinants to reduce health inequities. However, we have no doubt that there are also human rights workers who remain unconvinced of the value of specific efforts aimed at health equity through a social determinants approach. Giving the challenging task of realizing human rights, some human rights advocates may maintain either that their existing actions are the most important route to reducing health inequities among other aims, or that attention to social determinants is an unproductive diversion from the main work of implementing rights-based approaches. Finding common cause with the health equity movement in any substantive way will require significant effort to move beyond the traditional emphasis on claims and legal instruments, to showing how the right to health can be applied throughout government and by other actors in a prospective manner to improve policies, service delivery, and the allocation of resources. The health equity movement also faces this challenge. Perhaps, working with this emphasis, the intersecting movements can find common purpose.

On a final note, we suggest that the social determinants of health discourse and evidence base (for which the CSDH's final report provides a beacon) have much to offer those interested in rights-based

approaches to health. Contributing to action on social determinants enables the clear construction of the right to health as much more than the right to health care, a confusion that continues to be commonplace. Even where there is no confusion, rights-based approaches seem to continue to focus health discussions on health care services. This is reflected in the cases on which the Special Rapporteur on the Right to Health has been asked to advise; it is also evident when considering the key achievements of rights-based approaches and even the bulk of the literature. We disagree with the conclusion of some, that the right to health cannot support action on social determinants for populations, but seek assistance from our human rights colleagues in conclusively demonstrating this capacity.⁴⁴

Moreover, health inequities are glaring evidence of violations of the right to health and other human rights for both individuals and communities. The CSDH's final report has clearly shown that these inequities are not in any way natural or inevitable. Policy action to address social determinants, and the increasing global momentum to do so, are essential levers to realize the right to health. Measurement of inequities and indicators of social determinants can also contribute to accountability frameworks on the realization of the right to health in a mutually supportive manner. Countries that have reduced health inequities have generally done so in ways that have seen the realization of human rights, particularly for disadvantaged communities, through measuring health inequities, improving the quality and coverage of health care, and facilitating broader social development through policies acting on the social determinants.⁴⁵

A deeper engagement with the health equity movement and the social determinants discourse could, therefore, assist those who are implementing rights-based approaches to health in their primary agenda. Both calling for action on social determinants and advancing rights-based approaches represent regrettablely marginal perspectives in global health policy. Making the effort to understand and bridge the differences between the health equity and human rights movements, and mutually taking advantage of their comparative strengths, seems an opportunity for those who seek social justice in health that should not be missed.

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