Abstract and Keywords

This chapter discusses the role of law and human rights in socioeconomic health inequalities in Europe. Given that socioeconomic health inequalities are largely unnecessary and avoidable, it is widely claimed that they lead to health inequities (i.e., avoidable inequalities in health). Addressing health inequities is considered to be an ‘ethical imperative’ and a ‘matter of social justice’. Human rights standards provide a moral and legal framework for assessing matters of social justice, including socioeconomic health inequalities. This chapter analyses how the main European organizations (EU and Council of Europe) address health inequalities. Specific attention is paid to the role of human rights law as a tool that may give support and priority to improving health and reducing inequities. By way of explaining how social determinants are addressed at the domestic level, the chapter discusses (the approaches to) socioeconomic health inequalities in the United Kingdom and the Netherlands. The chapter establishes that while not as dramatic as in the United States, socioeconomic health inequalities are a reality in Europe, and that inequalities have widened both between and within European countries. It concludes that reducing health inequalities should be a key priority in European and domestic health policy, and that human rights law plays an important role in informing what needs to be done.

Keywords: human rights, socioeconomic health inequalities, Europe, health inequities, European institutions, European government, domestic law, public health, European Union, social determinants

1 Setting the Scene

It is widely evidenced that there are dramatic health inequalities (i.e., differences in health status) both within and between countries. An important contributor to these health inequalities are the conditions in which we are born, grow, live, work and age: our social determinants of health.\(^1\) Important social determinants include one’s education, family income, housing, and employment status. Where such conditions and not biological variations or free choice are at the root of inequalities, we call them “socioeconomic
health inequalities.” Socioeconomic health inequalities are generally considered to be unnecessary and avoidable.

As such, four interrelated concepts play a key role in this chapter: health inequalities, the social determinants, socioeconomic health inequalities, and health inequities. Throughout the chapter, these terms are used to some extent interchangeably, also because they are not always clearly distinguished in the literature. The term “health disparities,” which is most similar to “health inequalities,” is more common on the American continent.

How does legal scholarship and practice come into play in this context? Given that socioeconomic health inequalities are largely unnecessary and avoidable, it is widely claimed that they lead to health inequities (i.e., avoidable inequalities in health). Addressing health inequities is considered to be an “ethical imperative” and a “matter of social justice.” This, first, leads us to the role of human rights. Human rights standards provide a moral and legal framework for assessing matters of social justice, including socioeconomic health inequalities. Given that the European institutions and domestic European government are strongly grounded in the European human rights tradition, this chapter pays attention to how human rights have thus far been framed in relation to socioeconomic health inequalities in Europe.

At an operational level, domestic law and policy play a crucial role in connection with social and public health concerns. As also discussed by Wendy E. Parmet (“Social Determinants in the United States,” in this volume), law is itself a social determinant by structuring and perpetuating our social conditions. The relationship between law and health is very complex, also because laws and policies influence our health both in direct and indirect ways. For example, a rule that increases the price of tobacco may boost the health of those who manage to quit directly. Laws that are less related to health, also called “incidental laws,” may influence our health indirectly. For example, laws that govern terms and tenure of employment may influence the resources available to people to access tobacco cessation or to pay for cigarettes if they wish to continue smoking.

Assuming that health inequalities born out of social determinants are unjust, we need to identify how human rights standards and specific laws can be best employed to improve social conditions. This is a very complex and ambitious question that can only lead to partial answers. In an attempt to create some clarity over how this matter plays out in Europe, this chapter looks at how the European institutions and domestic European governments have thus far addressed socioeconomic health inequalities.

First, a brief overview is provided of the current data on health inequalities in Europe, with a main emphasis on the European Union (EU) region where most of the existing health research has been carried out. Subsequently, attention is paid to the main European organizations (EU and Council of Europe) and their role in addressing health inequalities. In this context, specific attention will be paid to the role of human rights law as a tool that may give support and priority to improving health and reducing inequities.

Next, by way of explaining how social determinants are addressed at the domestic level,
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Attention is paid to socioeconomic health inequalities in the United Kingdom and the Netherlands.

(p. 173) By way of a disclaimer, it should be observed that the European legal landscape is very complex, both from a geographic and from a governance perspective. It encompasses two international organizations with a geographic scope and mandate in an interaction with a wide range of nation states with distinct domestic jurisdictions.

2 Health Inequalities in Europe

While considerable progress has been made when it comes to improving overall population health in the European region, health inequalities have generally widened over the past decennia. These inequalities were even witnessed by more affluent countries and have been exacerbated by the economic crisis from 2008 onward.

Death rates and poorer self-assessments of health were higher in groups with lower socioeconomic status (SES). Less affluent and less educated people in the European Union have worse average levels of health than those with a higher income and education. These inequalities were larger in some countries than in others: for example, they were very large in most countries in the eastern and Baltic regions and small in some southern European countries.

(p. 174) Both behavioural (smoking, alcohol) and structural factors ("poverty, and national economic, policy-related and structural conditions") contributed to between-country variations in socioeconomic inequalities in mortality. Several studies confirm that differences in health behaviours related to tobacco consumption, obesity, and harmful use of alcohol contribute significantly to health inequalities. Other chapters in this volume address legal responses to behavioural factors. In this chapter, the focus is on the structural factors that cause health disparities, sometimes through their effect on the behavioural factors, as when low income increases the likelihood of tobacco consumption. The existing research shows the vulnerability of certain groups in European society, including minority ethnic groups such as the Roma and (undocumented) migrants. Childhood poverty and development also receive particular focus and attention based on the insight that these have a strong influence on health and other outcomes later in life.

While inequalities persist, they are not as dramatic as in the United States. A recent study suggests that trends in health inequalities have been more favourable in Western Europe than in the United States. It found that no Western European country experienced the recent increases in mortality reported in the United States, which have been attributed to greater socioeconomic inequalities, less comprehensive social security arrangements, and widespread availability of dangerous prescription drugs. The fact that European healthcare systems are more comprehensive also plays a role in constraining inequalities.
3 The Role of the European Union and the Council of Europe

3.1 The European Union’s Approach Toward Health Inequalities

The European Commission, as the main executive force of the European Union, has explicitly recognized the existence of socioeconomic health inequalities in the EU region. It has adopted various strategies and policies in the field which will be briefly discussed.

To start with, what has encouraged the European Union to take action to address the social determinants? Health as an element of a productive economy is a key rationale underpinning the European Union’s policies. The European Union’s 2020 agenda for growth and jobs emphasizes the need for health policy as “keeping people healthy and active for longer has a positive impact on productivity and competitiveness.” Along similar lines, the European Union sees reducing poverty and social exclusion as a means to enhance sustainable and inclusive growth and as one of the ways to overcome the structural weaknesses in the EU economy.

In a 2009 Communication, the European Commission expressed concern about the large gaps in health between and within EU Member States. In 2013, it followed with an extensive staff working document on health inequalities in the EU region, identifying EU policies addressing health inequalities and the social determinants of health. It stressed that achieving greater health equality involves cooperation among a broad range of policy areas, including “health, social affairs, research, education, energy, agriculture, development and regional policies.” While it referred to existing strategies in all these areas, the European Union’s cooperation among these dimensions remains somewhat underexplored. All actions remain at a policy level and do not (yet) have any specific implementation in law apart from specific regulation in the areas of tobacco and alcohol.

It is worth noting that the European Union’s approach is to some extent grounded in the European human rights tradition encompassing also social rights, including the right to health. The above-mentioned report took as a starting point for action in relation to the social determinants Article 35 of the Charter of Fundamental Rights of the European Union (CFREU), which recognizes the right of access to preventive healthcare and the right to benefit from medical treatment. It also endorsed the UN Convention on the Rights of Persons with Disabilities (CRPD), to which the European Union became a party in 2010 and which contains the right to the highest attainable standard of health of persons with disabilities. By starting from the EU Charter and the UN Convention, the EU approach has focused more on the health effects of social determinants than on the social determinants themselves.

The report also paid attention to EU action on chronic diseases with the aim of pointing out the concrete action taken to reduce inequalities in chronic disease control and incidence. In this context, the Commission referred to several strategies aimed at improving
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treatment as well as at addressing behavioural risk factors including smoking, unhealthy diets, and excessive use of alcohol. To give one example, the European Pact for Mental Health and Well-Being seeks to address health inequalities by destigmatizing mental health issues and by improving mental health services. The report stressed that action on mental health is particularly important in addressing inequalities because “people from less advantaged socioeconomic groups are more vulnerable to mental health problems, and mental health problems may themselves be a reason for weak performance at work or in school, or for social exclusion.”

As to regulating risk factors, the report signalled that “differences in the prevalence of smoking between advantaged and disadvantaged groups are responsible for a significant proportion of the differences in death and disease rates between these groups.” It indicated that regulation to make tobacco products “less attractive, advertising bans, pricing policy and smoke-free areas are [therefore] important in addressing social inequalities in tobacco use.” This is a field where the European Union has been most proactive from a regulatory perspective. As discussed by Amandine Garde elsewhere in this volume, the European Union has adopted a range of binding and nonbinding measures in relation to tobacco use and other behavioural risk factors. The ability of EU Member States to restrict the marketing of tobacco and unhealthy food and beverages has also been the subject of the case law of the European Court of Justice.

The preceding discussion shows that the European Union has clearly embraced the social determinants. To my knowledge, no systematic research has thus far been carried out measuring whether these efforts have been effective. Furthermore, much of the action aimed at reducing socioeconomic health inequalities is focused somewhat narrowly on addressing the effects of social determinants, in particular behavioural risk factors including smoking, excessive use of alcohol, and unhealthy diets.

3.2 The Council of Europe

With 47 Member States, the Council of Europe is a much larger organization than the European Union, and its mandate concerns the observance of democracy and human rights. The Council of Europe has expressed interest in social determinants such as education, housing, and employment while recognizing the existence of health inequities. Yet, unlike the European Union, it has not developed targeted strategies or programmes in relation to the social determinants of health or reducing health inequalities.

The importance of the Council of Europe in relation to social determinants should nonetheless not be underestimated. As the primary intergovernmental human rights organization in Europe, the organization provides an important framework for addressing the social determinants through the lens of human rights. Even though currently the organization does not address the social determinants explicitly, its sophisticated human rights mechanisms provide a moral and legal framework for analyzing socioeconomic health inequalities in Europe. Hence we need to find out how this human rights mechanism has
thus far offered protection against health inequalities and how it may be employed more effectively in the future.

Before discussing the Council of Europe framework, some general words need to be devoted to how human rights can play a role in addressing the social determinants and health inequalities. According to Marmot et al., “Human rights approaches support giving priority to improving health and reducing inequities.” Human rights law makes clear appeals to the governmental authorities at all levels to take action when injustices in health and other social fields occur. As suggested earlier, health inequalities arise from the conditions in which people are born, grow, live, and work. If we translate this understanding to human rights law, this suggests that human rights should guarantee not only an entitlement to healthcare but also an adequate physical environment and social conditions.

Without doubt, the prime right in this field is the right to health as recognized in a wide range of human rights treaties, both at international and regional levels. To cite Hunt, former UN Special Rapporteur on the Right to Health, about the relation between the right to health and the social determinants: “there can be no doubt that the right to the highest attainable standard of health encompasses social determinants....Addressing harmful social determinants is also a legal imperative. Reinforced by law, human rights are equity and ethics with teeth.” Both the right to health under the UN International Covenant on Economic, Social and Cultural Rights (ICESCR) and the right to protection of health under the (Revised) European Social Charter (ESC) reflect a broad approach to health, including not only access to healthcare but also the “underlying” or social determinants. This approach to the right of health is important for the recognition and protection of social determinants.

In addition, it is important to connect the right to health to other human rights that relate to and reflect the determinants of health, including the right to life, the rights to information and participation, and the rights to an adequate standard of living, social security, food, housing, property, education, and employment. These rights imply legal obligations to ensure access to housing, a safe and clean living environment, education, and social protection. As such, they carry the potential to address the health consequences of poor housing conditions, lack of access to proper education, and occupational health hazards.

So how have the Council of Europe’s human rights treaty bodies thus far dealt with the social determinants? While the collective complaint procedure under the European Committee of Social Rights, the treaty body of the European Social Charter, has thus far not addressed the social determinants explicitly, this mechanism holds potential for taking on this role in the future. First, from a procedural perspective, the collective complaint procedure allows for the representation of an affected group rather than an individual complainant, for example an indigenous population or a group of workers whose rights have been affected. As such, it may generate accountability for health inequalities in the way they usually affect not just individuals but larger groups of people.
Furthermore, the jurisprudence on the substantive rights in the Council of Europe’s European Social Charter currently reflects specific dimensions of the social determinants, including industrial pollution and healthy working conditions; access to housing facilities; and access to food, clothing, and shelter, as well as access to sexual and reproductive health education. In the decision in *ECCR v. Bulgaria*, the European Committee of Social Rights came close to recognizing the social determinants of health and health inequalities by stating that Bulgaria had failed to “take reasonable steps to address the specific problems faced by Roma communities stemming from their often unhealthy living conditions and difficult access to health services.” The failure of the authorities to take appropriate measures to address the exclusion, marginalization, and environmental hazards to which Romani communities were exposed, as well as their problems in accessing healthcare services, led the Committee to conclude that Bulgaria had violated the right to protection of health (Article 11) and the right to medical assistance (Article 13) in conjunction with the principle of nondiscrimination (Article E) of the European Social Charter.

The European Court of Human Rights (ECtHR) of the Council of Europe, as the court overseeing the implementation of the European Convention on Human Rights (ECHR), primarily deals with individual complaints and is thus less group-oriented. In addition, it mainly engages with the civil and political rights in the ECHR, rather than the social rights which are so key to realizing the social determinants. Nonetheless, the importance, influence, and potential of this court in the field of health should not be overlooked. As asserted by Hendriks, the ECtHR has increasingly come out with “far-reaching judgments in the fields of health and medicine, based on the assumption that healthcare represents an important value in society.” While the ECHR does not contain a right to health or healthcare, based on the ECtHR’s case law several (positive) obligations are imposed on contracting States relevant to health-related concerns. These obligations are based on several rights in the ECHR, including Articles 2 (life), 3 (prohibition of torture), 8 (privacy and family life), and 10 (freedom of expression and access to information). Health concerns that the ECtHR has touched on include a denial of access to medical care and dysfunctional health systems, protection of vulnerable persons in healthcare settings and involuntary confinement, access to personal data, abortion, euthanasia, forced sterilization, and environmental health matters. Thus far, the ECtHR has not addressed the social determinants or health inequality directly; however, the focus on environmental health matters may reflect one step in that direction.

### 4 Domestic Approaches: Failures and Successes

This section discusses how two European countries (i.e., parts of the United Kingdom and the Netherlands) have framed their strategies and policies in relation to the social determinants of health and to reducing health inequalities. While this country selection is by no means representative of Europe’s overall domestic approach towards the social determinants of health, it gives some insight into how European countries approach the social determinants and health inequalities and what has been achieved so far.
by two Western European countries that can, to some extent, be qualified as good practice countries.

The choice of these two counties is to some extent determined by the availability and accessibility of evidence on outcomes and policies on social determinants. But it also reveals different levels of engagement with the social determinants: while British approaches have been grounded explicitly in the social determinants, in the Netherlands the focus is mostly on addressing health inequalities. In light of these analyses, the concluding section will evaluate Europe’s efforts to address health inequalities and the social determinants of health. This will lead to some more general observations on the role of law and public health law more specifically in relation to the social determinants of health.

### 4.1 United Kingdom: England and Scotland

England in particular and the United Kingdom in general have a long history of engagement with socioeconomic health inequalities. They were front-runners when it comes to collecting systematic data in the field. The Whitehall studies, carried out in the 1970s and 1980s, investigated social determinants of health among British civil servants in the area of Whitehall in London, with a main focus on cardiovascular disease prevalence and mortality rate. These studies, which were led by Marmot, found a correlation between levels of employment and mortality rates: the lower the grade, the higher the mortality rate.

In 1980, the Black Report was published by the (former) Department of Health and Social Security, which demonstrated widespread health inequalities and proposed a radical change in social and healthcare policies.

English strategies and policies to reduce socioeconomic health inequalities have been adopted in stages. A 1999 action report, adopted in response to a 1998 inquiry with a range of recommendations, listed a range of new government policies including the introduction of a national minimum wage, higher benefits and pensions, and increased spending on education, housing, and healthcare. Subsequently, in 2003, a revised strategy was published by the Department of Health with twin aims: to deliver a national health inequalities target by 2010 (reducing inequalities in infant mortality and life expectancy at birth) and to support a long-term sustainable reduction in health inequalities. It reiterated the need to tackle the structural determinants but with a stronger emphasis on local policies, including, for example, improved social housing and reduced poverty among vulnerable populations and improved access to public services in disadvantaged communities.

In 2009, when it became clear that targets to reduce life expectancy and infant mortality by 10% were not being met, Marmot was appointed to chair an independent review to propose evidence-based strategies. The 2010 “Marmot Report” entitled “Fair Society, Healthy Lives,” while reiterating earlier health outcomes about health inequalities, was critical about the previous strategies, indicating that these focused insufficiently on the background causes of ill health by relying increasingly on tackling proximate causes such as smoking. Furthermore, target groups were insufficiently reached and local communi-
ties were insufficiently involved: more deprived people living outside spearhead areas and local government and other local public sector partners should have been included to a greater extent. The Marmot Report contains six policy objectives: (1) Give every child the best start in life; (2) enable all children, young people, and adults to maximize their capabilities and have control over their lives; (3) create fair employment and good work for all; (4) ensure a healthy standard of living for all; (5) create and develop healthy and sustainable places and communities; and (6) strengthen the role and impact of ill health prevention. The UK government explicitly embraces this approach to the social determinants of health and identifies action on its governmental website.

Similar efforts to adopt policies explicitly tackling socioeconomic health inequalities have been made in Scotland, where concern has been raised over “deep-seated inequalities” despite an overall improvement of health. It is reported that children in the most deprived areas “have significantly worse health compared to children living in the least deprived areas,” being more prone to low birth weight, poorer dental health, higher obesity levels, and higher rates of teenage pregnancy. Especially indicators like healthy life expectancy, mental health, smoking, and alcohol and drug misuse remain significantly worse in the most deprived parts of Scotland. On its website on “health and poverty,” the Scottish Government explicitly endorses the Marmot approach, makes explicit links between the social determinants and the human rights framework, and identifies tools for action.

The Marmot Report has had a significant impact on the design of policies and strategies in the United Kingdom and in other parts of Europe. Statistics nonetheless suggest that the British strategies to reduce socioeconomic health inequalities may not have been that effective. A 2017 governmental report focusing on England specifically establishes that stark inequalities remain. The report indicates that the most recent data on England show “wide inequalities across all indicators related to child health, mental health, smoking, alcohol misuse, and TB, and no trend indicating a clear narrowing of these inequalities.”

It seems extremely difficult—as suggested by Mackenbach “beyond our means”—to reduce health inequalities, requiring efforts that may be in “excess of what western state machineries can deliver,” such as changing the redistribution of income and wealth, measures which may lack political support. Yet there is also some reason for hope that certain targeted actions may have been effective. For example, a systematic review by Bambra et al. carried out between 2007 and 2010 in the United Kingdom suggests that certain categories of intervention have impacted positively on inequalities or on the health of specific disadvantaged groups, particularly interventions in housing and the work environment. For example, the review refers to evidence that rent assistance led to improvements in health and health status and that organizational-level work reorganization had a positive impact on self-reported health.
4.2 The Netherlands

A review by Kulhánová et al. reveals that, in the Netherlands, people in lower educated groups have a "higher prevalence of a less than good perceived general health, more chronic diseases, higher disability rates and higher risks of all-cause mortality compared to higher educated groups." While these inequalities were similar to other Northwestern European countries, the authors found larger inequalities in the Netherlands than elsewhere for lung cancer as a cause of death, which led this and several other studies to conclude that the level of education was a strong indicator for lifestyle-related diseases, in particular lung cancer as caused by smoking.

Dutch action in relation to socioeconomic health inequalities started in the 1980s, in response to the publication of the above-mentioned Black Report in England and a report on health inequalities between neighbourhoods in the city of Amsterdam. Gradually, the interest among policymakers to address socioeconomic health inequalities rose, further strengthened by the “Health for All by the Year 2000” targets of the World Health Organisation (WHO).

Governmental policies addressing socioeconomic health inequalities have fluctuated depending on the willingness of governments to take action. Dutch policies and approaches evolved from a broad concern about socially and economically marginalized groups in the 1980s to specific concerns about socioeconomic differences in the 1990s. Throughout these years, the emphasis has been on addressing socioeconomic health inequalities rather than on the social determinants. As such, the approach may have been somewhat different from the United Kingdom, where the social determinants approach is clearly embraced, clearly resonating the language from the Marmot Review.

From the early 1990s onwards, the Dutch Ministry of Health followed a systematic research-based approach to tackling socioeconomic inequalities in health. While an initial 5-year research programme mapped the nature and determinants of socioeconomic inequalities in health, a second 6-year programme was aimed at gaining systematic experience with interventions and policies aimed to reduce health inequalities. In response to these efforts, the government adopted a range of policy goals to increase life expectancy of the lowest socioeconomic group by 3 years by 2020. Important goals were decreasing inequalities in education and employment and increasing the accessibility of healthcare facilities to persons with low socioeconomic status.

However, despite pressure from governmental advisory bodies, the attention for this approach dropped at the beginning of this millennium, with governmental policies emphasizing individual responsibility. As a result, the Minister of Health shifted the responsibility to tackle health inequalities to the large cities as part of the Urban Policy Framework. In turn, the cities chose to focus specifically on excess weight in minors. With the new 2007 government, political concerns about health inequalities revived with a new governmental approach entitled “Towards an Able-Bodies Society.” However, these plans lacked a clear, coordinated approach, and clear targets were not set.
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The new 2017 governmental agreement contains clear statements on prevention; however, a clear strategy on tackling socioeconomic health inequalities is lacking. The subsequent National Prevention Agreement, launched in November 2018, focuses mainly on reducing risk factors and sets a range of targets in this field in collaboration with 70 societal partners.

A recent report from the Dutch Scientific Council for Government Policy suggests a different direction in the debate by emphasizing the importance of health potential instead of health inequalities. Along these lines, specific attention should go to the first 18 years of life, people with low socioeconomic status, and addressing four behavioural risk factors (i.e., tobacco use, excessive use of alcohol, unhealthy diets and lack of physical exercise). This reflects an attempt to redesign new approaches to social determinants of health: instead of a focus on inequalities, focus on improving the health status of the vulnerable in society.

5 Discussion

This chapter has addressed approaches towards socioeconomic health inequalities in Europe, looking both at regional and domestic practices. It is difficult to draw comprehensive conclusions given the variety in health outcomes as well as the varying approaches taken to address inequalities at both regional and domestic levels.

Firstly, it is important to establish that, while not as dramatic as in the United States, socioeconomic health inequalities are a reality in Europe. Statistics suggest that health inequalities have widened, both between and within European countries. We may conclude that when it comes to building a healthier European society, reducing health inequalities should be a key priority.

The European Union, as well as many domestic European states, has adopted dedicated strategies, policies, and laws to take action to reduce socioeconomic health inequalities. If and to what extent these measures have worked is difficult to measure. Evidence suggests that some targeted interventions have been effective, including the regulation of risk factors such as smoking. Yet given that the causes of inequalities are engrained in the structures of our society, the focus should not only be on regulating risk factors specifically, but also on structural factors, including poverty, lack of income, unemployment, and housing conditions. It remains, however, extremely challenging to adopt more comprehensive governmental policies as well as targeted laws in relation to these broader structural factors and to measure their overall effectiveness.

For the purposes of this volume, a specific question arises: What is the potential of law in this context? At a foundational level, human rights law can play a role in addressing social justice and reducing socioeconomic health inequalities. By giving expression to the vulnerability of the individual, human rights law can serve as an overarching framework protecting the rights and interests of those affected by health inequalities and poor social conditions. Taking a human rights approach then also requires looking at the right to
health in an interaction with other human rights, including rights to housing and social security, as well as labour rights. This chapter has made it clear that, in Europe, and much more than in the United States, social rights are a strong potential driver for addressing socioeconomic health inequalities. EU policies in this field should be explicitly grounded in social rights, as defined by the human rights framework of the Council of Europe and the EU’s Fundamental Charter.

In settings where these social rights are not recognized directly, Wesson suggests that we could also recognize “social condition” as a kind of unlawful discrimination, in addition to other existing kinds such as sex and age. While equality may not lead to an obligation to provide services like healthcare, it would allow courts to decide cases in (p. 186) which a group has been excluded from a certain social service or situations where the state curtails social programmes.78

From an accountability perspective, it is important for courts and other accountability mechanisms to have an understanding of health inequities and social determinants and of how human rights come into play in this context. So far, there is little experience with this matter. The European Committee of Social Rights, Council of Europe’s treaty body for the European Social Charter, addresses the social determinants to some extent under the umbrella of the social rights in the Charter. In this context the substantive social rights, including the right to health, housing, social security, and education, are used to address social conditions directly.

At a more applied level, we ask what the role of law is in reducing socioeconomic health inequalities. Burris and others have pointed out that law is both a vehicle through which health inequalities are exacerbated and a tool to reduce them and to improve social determinants.79 The role of law in relation to the social determinants of health is incredibly broad-ranging and extends to many fields, including the regulation of agriculture and food production, education, work environment, income, housing, and the overall socioeconomic and environmental conditions. In this context, it is important not only to focus on the effects of particular laws, but also to investigate the utility of law more generally as a mechanism for advancing health.80 It is obvious that (public) health law cannot play a role in all these areas. It is nonetheless crucial for public health lawyers to have an understanding of how these broader laws, sometimes called “incidental” public health laws, impact on health.81

Academic research on the role of law in relation to the social determinants of health in Europe is scant compared to what has been done in the United States. According to Burris, it is “important to know whether policies intended to improve our health are working.”82 To fully understand how law is implicated in the social determinants, more empirical legal research exploring the impact of law needs to be conducted in Europe. To give just one example of what can be done: in recent research carried out in the United States, increases in the state-level minimum wage above the federal value were associated with a reduction in heart disease death rates among individuals aged 35–64 years.83
Health inequalities and social determinants are an important phenomenon in our society. They demand action, and human rights and domestic law have a crucial role to play in framing what needs to be done. This chapter has demonstrated that when it comes to identifying the role of law and human rights in Europe, we are only scratching the surface.

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Notes:


(4) Burris (n 3). See also the conclusions to his chapter.


(6) In conversation with Scott Burris. For the identification of incidental laws see Burris (n 3), 1663.

(7) The European Union (EU) is an economic and political union of 28 European countries. The Council of Europe is an intergovernmental organization whose primary aims are to uphold human rights, democracy, and the rule of law in Europe. With 47 Member States, it has a much wider reach that the EU but less regulatory powers.

(8) JP Mackenbach et al., “Changes in Mortality Inequalities over Two Decades: Register Based Study of European Countries” (2016) BMJ, 353, i1732. WHO Europe, Review of So-
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(9) WHO Europe (2013 n 8), xiii (although Mackenbach et al., 2018, take a different viewpoint).


(12) Mackenbach et al. (2008 n 10), 2468.

(13) Mackenbach et al. (2017 n 10), 44–53.


(15) For the Roma, see in particular WHO Europe (2013 n 8).

(16) WHO Europe (2013 n 8), xxi.
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(19) Mackenbach et al. (2018 n 17).


(21) In conversation with Tamara Hervey, August 2019.


(26) Id., 10-17.

(27) It is thus important to note that this Charter, which constitutes the fundament of the EU when it comes to guaranteeing fundamental rights in the EU, also embraces a right to prevention.

(28) Id., 10. This refers to report in note 25.

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(30) Id., 12.

(31) Id., 11 and 12.

(32) See the chapter by Garde, in this volume.


(36) Toebes and Stronks (2016 n 35), 513.


(38) Toebes and Stronks (2016 n 35), 514.

(39) The interdependence of rights was also affirmed in the Vienna Declaration and Programme of Action, UN Doc. A/Conf.157/23, 12 July 1993, para 5, as adopted during the World Conference on Human Rights, Vienna 1993.

(40) Toebes and Stronks (2016 n 35), 514.

(41) Relevant decisions of the ESC Committee include Marangopoulos v Greece (30/2005); ATD Fourth World v France (33/2006); INTERIGHTS v Croatia (45/2007); ECCR v Bulgaria (46/2007); DCI v the Netherlands (47/2008); FIDH v Greece (72/2011); and CEC v the Netherlands (90/2013). See also Toebes and Stronks (2016 n 35), 12.

(42) ESC Committee, ECCR v Bulgaria (complaint no. 46/2007), para 49.

(43) Id., para 51.


(45) Id., 43 and 50.0
Examples include dysfunctional health systems: e.g., ECtHR Asiye Genc v Turkey, 27 January 2015, no 24109/07 and Vasileva v Bulgaria, 17 March 2016, no 23796/10; involuntary confinement: ECtHR 16 June 2005, Storck v Germany, no 61603/00 ECtHR 13 January 2009; access to personal data: ECtHR 4 May 2000, Powell v the UK, no 45305/99; abortion: ECtHR 5 September 2002, Boso v Italy, no 50490/99; euthanasia: ECtHR 29 April 2002, Pretty v the UK, no 2346/02; and environmental health protection: ECtHR 9 June 2005, Fadeyeva v Russia, no 55723/00. For a comprehensive overview (updated until 2012) see Hendriks (2012 n 44).


Mackenbach (2010), 1249. (reference to note 48)


Mackenbach (2010 n 48), 1250.


Marmot Review (n 53), 90; and Mackenbach (2010 n 48), 1251.

Marmot Review (n 53), executive summary.


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(60) Mackenbach (2010 n 48), 1251.


(64) Id., 694.


(66) WHO, Targets for Health for All (Copenhagen: WHO 1985); Mackenbach and Stronks (2004).


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(71) Id.

(72) Droomers et al. (n 67), 17.


(74) Droomers et al. (n 67), 17.


(81) Burris (n 3), 1663.

(82) Id., 1662.


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