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Closing the Gap: A Human Rights Approach towards Social Determinants of Health

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Abstract

Social determinants of health are major contributors to population health as well as health inequalities. The public perception that health inequalities that arise from these social determinants are unjust seems to be widespread across societies. Nevertheless, there is also scepticism about the progress in the implementation of actual policies to reduce health inequalities. Scholars, activists and policy makers from various disciplinary backgrounds increasingly stress the value of the *human rights approach* to support policies addressing health inequalities, and to hold actors in policies to address social determinants accountable for these inequalities. The 'right to health', in conjunction with the other health-related human rights, captures most elements of social determinants of health, and makes clear appeals to the governmental authorities at all levels to take action when social injustices occur. Existing judicial and non-judicial cases show us how human rights can be instrumental in addressing inequalities in health.

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Keywords

public health – health inequalities – social determinants of health – human rights – right to health – European context – multidisciplinary scholarship

1 Introduction

Social determinants of health are major contributors to population health as well as health inequalities. In ‘Closing the Gap in a Generation’, the WHO Commission on Social Determinants of Health (CSDH) concludes that health inequalities arise because of the unequal distribution of power, income, goods, and services and because of the circumstances in which people live, including their access to healthcare, education, their conditions of work and leisure, their homes, and communities.¹

The public perception that health inequalities that arise from these social determinants are unjust seems to be widespread across societies. Nevertheless, there is also scepticism about the progress in the implementation of actual policies to reduce health inequalities. In other words, there seems to be ‘a gap between rhetoric and performance.’² Brown et al. in a recent report that aimed to inform the WHO on the Health 2020 strategy, identified a number of reasons for the persistence of health inequalities, despite good intentions.³ These include ‘the failure to develop an effective “control strategy” capable of holding all stakeholders to account for delivery of actions necessary to reduce inequities’ (p. 42).

Against this background of failures in the political and accountability system, scholars, activists and policy makers from various disciplinary backgrounds increasingly stress the value of the *human rights approach* to support policies addressing health inequalities, and to hold actors in policies to address social determinants accountable for these inequalities. E.g., the European Review for

1 World Health Organization/Commission on the Social Determinants of Health, *Closing the Gap in a Generation. Health Equity through Action on the Social Determinants of Health* (Geneva: WHO, 2008).

2 M. Marmot, J. Allen, R. Bell, and P. Goldblatt, ‘Building of the global movement for health equity: from Santiago to Rio and beyond’, *Lancet* 379 (2012) 181-188.

3 C. Brown, D. Harrison, H. Burns and E. Ziglio, *Governance for Health Equity. Taking forward the Equity Values and Goals of Health 2020 in the WHO European Region* (Copenhagen: WHO, 2014).

Social Determinants of Health (2012), chaired by Sir Michael Marmot, states that 'Human rights approaches support giving priority to improving health and reducing inequities'.⁴

These statements form an important appeal to the human rights community to explain how reducing health inequalities can be tackled through human rights language. Indeed, several human rights scholars have attempted to underline the intersection between the social determinants of health and human rights.⁵ This article builds on these efforts by identifying the human right instruments that offer opportunities to support and promote health equity in a broad spectrum of policies that address social determinants of health and by discussing how human rights can be employed to hold the responsible actors in the health field to account for failures to address health inequities.

2 Human Rights Law Captures Most Social Determinants of Health

Human rights law consists of an authoritative, recognisable and universally applicable legally binding international value system. As such it is an important tool for addressing public health concerns that raise matters of social justice. Human rights law translates such injustices into concrete individual or collective claims towards governments; which again translate into concrete legal governmental obligations. As such human rights law makes clear appeals to the governmental authorities at all levels to take action when social injustices occur.

4 M. Marmot, J. Allen, R. Bell, E. Bloomer and P. Goldblatt (for the Consortium for the European Review of Social Determinants of Health and the Health Divide), 'WHO European Review of social determinants of health and the health divide', *Lancet* 380 (2012) 1011-1029.

5 P. Hunt, 'Missed opportunities: human rights and the Commission on Social Determinants of Health', *Global Health Promotion* 16 (2009) 36-44; S. Venkatapuram, R. Bell and M. Marmot, 'The right to sutures: social epidemiology, human rights, and social justice', *Health and Human Rights* 12 (2010) 3-16; A.R. Chapman, 'The social determinants of health, health equity and human rights', *Health and Human Rights* 12 (2010) 17-30; P. Braveman, 'Social conditions, health equity, and human rights', *Health and Human Rights* 12 (2010) 31-48; B. Toebes, A. Hendriks and K. Stronks, 'Health Inequalities and the Social Determinants of Health', in: B. Toebes et al. (eds.), *Health and Human Rights in Europe* (Antwerp: Intersentia, 2012), pp. 213-225.

As was stated by the CSDH, health inequalities arise from the conditions in which people are born, grow, live, work and age.⁶ If we translate this understanding into human rights law, this suggests that human rights should guarantee entitlement not only to healthcare services addressing physical needs, but also to conditions ensuring an adequate physical environment and social conditions, taking into account biological endowments, individual behaviours and needs.⁷

The 'right to health' as defined under international human rights law, is entirely founded on this broad understanding of health. This right to health, or more precisely the 'right to the highest attainable standard of health' is recognised, *inter alia*, in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). An important landmark for the definition of the right to health was the adoption of General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights (1999), which outlines the framework of the right to health in Article 12 ICESCR. Although the document is not legally binding, it is an authoritative source that gives a comprehensive explanation of the meaning and implications of Article 12 ICESCR.⁸ In paragraph 4, it affirms that the right to health has a broad scope:

[...] "the highest attainable standard of physical and mental health" is not confined to the right to health care. On the contrary, the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.

6 *Supra* note 1.

7 B. Toebes, 'Human Rights and Social Justice in Europe', in: I. Lintel, A. Buyse and B. McConigle Leyh (eds.), *Defending Human Rights: Tools for Social Justice* (volume in honour of Fried van Hoof), (Antwerp: Intersentia, 2013), pp. 109-25.

8 UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14: The Right to the Highest Attainable Standard of Health* (Art. 12 of the Covenant), August 11, 2000, UN Doc. E/C.12/2000/4, http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=11, retrieved 16 January 2016.

This understanding of the right to health, which builds on the WHO's broad definition of health, explicitly recognises that 'underlying determinants of health' are as important for people's health as the possibility to access health care services. The right to protection of health in the European Social Charter (ESC) is interpreted in a similarly broad fashion. In an explanatory document, the Secretariat of the ESC explains that Article 11 ESC covers numerous issues relating to public health such as food safety, protection of the environment, vaccination programmes and alcoholism, an approach which is also reflected by the case-law of the European Committee of Social Rights (see below).

In addition, it is important to connect the various health-related human rights together. Knowing that the ways we are raised, educated and work are decisive to our health, we should look into how the right to health is connected to other human rights that reflect the determinants of health. This approach is very much in keeping with the notion of the 'indivisibility, interdependence and interrelatedness' of all human rights, as was affirmed in the Vienna Declaration and Programme of Action, adopted in 1993 at the World Conference on Human Rights.⁹ General Comment 14 affirms that the right to health does not stand alone, but is reinforced and supported by several other rights:

The right to health is closely related to and dependent upon the realisation of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement. These and other rights and freedoms address integral components of the right to health [para. 3].

Other human rights that are closely linked to the social determinants of health include 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. Such rights imply legal obligations to ensure access to, *inter alia*, housing, a safe and clean living environment, education, and social protection. In conjunction with the right to health, these rights have

⁹ World Conference on Human Rights, *Vienna Declaration and Programme of Action*, UN Doc. A/Conf.157/23, 12 July 1993, para. 5.

the potential to address the health consequences of poor housing conditions, the lack of access to proper education and of people's neighbourhoods and their workplaces.

To make this approach more tangible and applicable, we should more precisely link state obligations under international human rights law to the CSDH goals, so as to find out whether they are fully covered by the legal obligations under the existing human rights framework. Going back to CSDPH's report 'Closing the Gap in a Generation', we see that the report launches three overarching recommendations for all actors to reduce health inequities: 1) improve daily living conditions; 2) tackle the inequitable distribution of power, money, and resources; and 3) measure and understand the problem and assess the impact of action.¹⁰ In connection with these 'principles of action' CSDH identifies twelve goals, including child development, fair employment and decent work, social protection, universal healthcare, health equity in all policies, gender equity, and political empowerment. For each specific goal, a set of human rights standards can be identified (see Table 1). For example when it comes to child development, a range of human rights treaty provisions apply that offer protection of various aspects of the development of the child.¹¹

In establishing these links it appears that many of the CSDH goals are fully encapsulated by the existing human rights standards. This applies e.g., to primary and secondary education and quality healthcare services. Yet some other aspects are not fully covered, such as investments in generating and sharing evidence on social determinants.¹² Clearly, more research is needed to clarify these cross-connections and to identify and bridge gaps between social determinants of health on the one hand, and the human rights approach on the other.

¹⁰ *Supra* note 1.

¹¹ Articles 24, 27-29 Convention on the Rights of the Child (health, standard of living, education), Article 11 ICESCR (food, clothing, housing), and Protocol 1 to the European Convention on Human Rights (right to education).

¹² *Supra* notes 1 and 8.

TABLE 1 *Social determinants as defined by the CSDH and human rights*

CSDH Goals	Specific CSDH Goals	Legal State Obligation	General Comment 14
1. Child development	<ul style="list-style-type: none"> – access to quality early child development programmes – early childhood development – quality compulsory primary and secondary education – preschool education programmes 	11 ICESCR (food, clothing, housing) 24 CRC (health) 27 CRC (standard of living) 28, 29 CRC (education) Protocol 1 to the ECHR (education) 11, 17 ESC (health, social protection)	Para. 14 and 22-24 GC
2. Living environment	<ul style="list-style-type: none"> – availability of affordable housing – investments in urban slum upgrading – promote health equity between rural and urban areas – counter the inequitable consequences of urban growth 	25 UDHR (standard of living) 11 ICESCR 21 CSR 11, 31 ESC	Paras. 9, 11 and 34 and 43-44 and 53-56 GC 14
3. Fair employment and decent work	<ul style="list-style-type: none"> – access to full and fair employment and decent work – safe, secure and fairly paid work, year-round work opportunities, and healthy work-life balance – adequate living wage – protection of workers 	6 and 7 ICESCR 11 CEDAW 17 and 18 CSR 27 CRPD ILO Conventions 25, 38 -71 MWC 1-10, 18-22, 25-28 ESC	Paras. 4, 15 and 51 GC 14

CSDH Goals	Specific CSDH Goals	Legal State Obligation	General Comment 14
4. Social protection	<ul style="list-style-type: none"> – universal comprehensive social protection policies that support a level of income sufficient for healthy living for all – social protection for those in precarious work, including informal work and household or care work 	9 ICESCR 13 CEDAW 26 CRC 24 CSR 27 MWC 13-14, 16, 23, 30 ESC	Paras. 15 and 51 GC 14
5. Universal health care	<ul style="list-style-type: none"> – quality health-care services with universal coverage, focusing on Primary Health Care – strengthen public leadership in healthcare – invest in national health workforces 	Right to health: 12 ICESCR / GC 14 12 CEDAW 24 CRC 5 CERD 28, 43, 45 MWC 24 CSR 25 ILO 169 25 CRPD 11 ESC	Paras. 12, 16-17, 43 GC 14
6. Health equity in all policies	<ul style="list-style-type: none"> – establishing health equity as a marker of government performance – impact assessments of health and health equity – adoption of a social determinants framework and building supports and structures to encourage this 	See above, 'right to health'	Paras. 12, 16, 18-27, 34 and 36 GC 14

TABLE 1 *Social determinants as defined by the CSDH and human rights (cont.)*

CSDH Goals	Specific CSDH Goals	Legal State Obligation	General Comment 14
7. Fair financing	<ul style="list-style-type: none"> – fairly allocate government resources for action on the social determinants of health – establish mechanisms to finance cross-government action on social determinants of health, and to allocate finance fairly between geographical regions and social groups 	12 ICESCR 2-1 ICESCR (‘progressive realisation’, ‘to the maximum of a State’s available resources’)	Paras. 52 and 53 GC 14
8. Market responsibility	<ul style="list-style-type: none"> – reinforce the primary role of the State in the provision of basic services essential to health – regulation of goods and services with a major impact on health 	12 ICESCR ‘obligation to protect’ of governments	Paras. 43-45 and 63-65 GC 14
9. Gender equity	<ul style="list-style-type: none"> – address gender biases in the structures of society – adopt legislation that promotes gender equity – develop and finance policies and programmes that close gaps in education and skills, and that support female economic participation – increase investment in sexual and reproductive health services 	1-5, 7-16 CEDAW	Paras. 10, 16, 20-21, 35 and 52 GC 14

CSDH Goals	Specific CSDH Goals	Legal State Obligation	General Comment 14
10. Political empowerment	<ul style="list-style-type: none"> – empowerment of groups in decision making about how society operates – create a role for civil society 		Paras. 11 and 54-55 and 59-62 GC 14
11. Good global governance	<ul style="list-style-type: none"> – make health equity a global development goal 	2-1 ICESCR: international assistance and cooperation	Paras. 38-42 and 63-65 GC 14
12. Knowledge, monitoring and skills	<ul style="list-style-type: none"> – availability of monitoring systems for health equity – investments in generating and sharing evidence on social determinants – training on the social determinants 	12 ICESCR (health-related information)	Para 56 GC 14

SOURCE: CSDH / THE AUTHORS.

Glossary of treaty abbreviations and their adoption dates: CRC: Convention on the Rights of the Child (UN, 1990); ECHR: European Convention on Human Rights (Council of Europe, 1952); ESC: (Revised) European Social Charter (Council of Europe, 1996); UDHR: Universal Declaration of Human Rights (UN, 1948); CSR: Convention Relating to the Status of Refugees (UN, 1954); CEDAW: Convention on the Elimination of All Forms of Discrimination against Women (UN, 1981); CRPD: Convention on the Rights of Persons with Disabilities (UN, 2007); MWC: Convention on the Protection of All Migrant Workers and Members of their Families (UN, 1990); ILO 169: Convention 169 of the International Labour Organisation (on indigenous and tribal peoples, 1989).

3 Towards Accountability

Subsequently we want to find out how human rights law can be used to seek ‘accountability’ for failures to address socio-economic health inequalities. As mentioned above, human rights are primarily legally binding norms that can lead to the assessment of cases by international and domestic judicial and

quasi-judicial bodies, in light of these standards. Examples of such cases, both at domestic and international levels, are still scarce, which may have to do with a reluctance on the part of courts to deal with the — often open ended- human rights standards. Yet there is a gradually expanding list of examples from all over the world that can exemplify how such cases can be dealt with. It is important to accumulate these efforts so as to enable cross-fertilisation between various international and domestic judicial bodies and also between public interest litigation groups. A new case law digest on 'health and human rights' gives many interesting examples of cases addressed at the domestic level, before judicial and quasi-judicial bodies, from different parts of the world.¹³

At the international and regional levels, examples of international bodies addressing health inequalities are still scarce. The collective complaint procedure under the European Committee of Social Rights, the treaty-monitoring body of the (Revised) European Social Charter (ESC), has produced several worthwhile examples (see Table 2). As a collective complaint mechanism, it is able to represent a larger group of people, for example a group of undocumented migrants, or an indigenous population. The case law of this Committee has touched upon various health-related concerns, including access to health-care for undocumented migrants, the occupational health concerns of miners in Greece, and the protection of the health of the Roma (Table 2). For example in the decision of *ECCR v. Bulgaria*, the Committee explicitly addressed the notion of social determinants of health and health inequalities with respect to the Roma in Bulgaria. It stated 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'.¹⁴

Clearly, the unhealthy living conditions were an important motivation for the Committee to conclude that the rights in the ESC had been violated. While the decisions of this Committee are not legally binding, they are influential and as discussed below can have a spill over effect for national courts cases addressing similar concerns, e.g. when it leads to political debate on the topic,

13 O'Neill Institute, Global Health and Human Rights Law Database, <http://www.law.georgetown.edu/oneillinstitute/research/ghhr.cfm>, retrieved 19 January 2016.

14 ESC Committee, *ECCR v. Bulgaria* (complaint no. 46/2007), para. 49 (see also Table 2). For an overview of all the decisions see the case law digest of the European Committee of Social Rights (HUDOC), <http://hudoc.esc.coe.int/eng/#>, retrieved 19 January 2016.

as was the case e.g. of *DCI v. The Netherlands* on access to housing for undocumented migrants (see below).¹⁵

TABLE 2 *Examples of accountability at the regional level; the practice of the European Committee of Social Rights (Council of Europe)*

Name and Date of Decision	Rights at Issue	Health-related Topic
<i>Marangopoulos v. Greece</i> (30/2005)	11, 2, and 3 (safety at work and healthy working conditions)	working conditions of people working in lignite mines
<i>ATD Fourth World v. France</i> (33/2006)	16, 30, 31 (protection against poverty and the right to housing) and E (non-discrimination)	denial of access to housing of persons in extreme poverty
<i>INTERIGHTS v. Croatia</i> (45/2007)	11, 16 (protection of the family) and 17 (protection of children)	access to sexual and reproductive health education in schools
<i>ECCR v. Bulgaria</i> (46/2007)	11, 13 (medical assistance) and E (non-discrimination)	access to health services for the Roma, and their general health conditions
<i>DCI v. the Netherlands</i> (47/2008)	11, 13, 16, 17, 30 (housing) and 31 (protection against poverty and exclusion)	access to housing and other facilities for undocumented children
<i>FIDH v. Greece</i> (72/2011)	11 (protection of health)	industrial pollution
<i>CEC v. the Netherlands</i> (90/2013)	13 (social and medical assistance), 31 (housing)	food, clothing and shelter for undocumented adults

15 ESC Committee, *DCI v the Netherlands*, Complaint no. 47/2008, 12 February 2008 (see also Table 2), <https://wcd.coe.int/ViewDoc.jsp?id=1534865&Site=CM>, retrieved 19 January 2016.

Public interest litigation groups often play a key role in bringing such matters to the courts. An example is the former Dutch law firm *Fischer Advocaten* (Haarlem, the Netherlands), which specialised in providing legal aid to persons living below the poverty level. For example, this law firm has addressed the withdrawal of social services, social aid or medical care, the refusal to provide shelter to homeless persons, but also the detention of adolescents without appropriate treatment and support.¹⁶ Together with Defence for Children International (DCI), it submitted a collective complaint to the European Committee of Social Rights concerning the homelessness of a number of undocumented children in the Netherlands.¹⁷ The Committee concluded that the Netherlands was in violation of several articles in the Charter. This decision caused parliamentary debate in the Netherlands and led a District Court to decide that an undocumented mother and daughter in a similar case were to be provided with shelter by order of the court.¹⁸ A 2013 decision of the European Committee on Social Rights concerning access to basic services for rejected asylum seekers in the Netherlands (the so-called 'bed, bath and bread' decision), caused even more uproar in parliament and in Dutch society at large, and almost led to a fall of the cabinet.¹⁹

Judicial decisions primarily address incidences rather than an a trend or development that affects a broader section of society, or society at large. Nonetheless as was evidenced above, court cases can have an important spill-over effect. As such they have significant implications for policy making and spending, and may also exert a preventive effect on future situations. It is therefore misleading to view litigation as entirely distinct from political strategies for attaining health rights.²⁰

16 Fischer advocaten, <http://www.fischeradvocaten.nl/index.php?&w=88>, retrieved 19 January 2016.

17 *Supra* note 15.

18 District court of Utrecht, interim measure, 6 April 2010, *LJN*: BMo846.

19 ESC Committee, *CEC v. the Netherlands*, complaint no. 90/2013, decision 1 July 2014 (see also Table 2), [http://hudoc.esc.coe.int/eng#{%22fulltext%22:\[%22cec%20v%20netherlands%22\],%22ESCDcIdentifier%22:\[%22cc-90-2013-dmerits-en%22\]}](http://hudoc.esc.coe.int/eng#{%22fulltext%22:[%22cec%20v%20netherlands%22],%22ESCDcIdentifier%22:[%22cc-90-2013-dmerits-en%22]}), retrieved 19 January 2016, and the related judgment of the Netherlands Central Appeals Court of 26 November 2015, *ECLI:NL:CRVB:2015:3803*, <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:CRVB:2015:3803>, retrieved 18 January 2016; see also Veronika Flegar, "Illegal immigrants" have basic rights — or do they not?, *Global Health Law Groningen Blog*, 16 April 2015, <https://ghlgblog.wordpress.com/2015/04/16/illegal-immigrants-have-basic-social-rights-or-do-they-not/>, retrieved 19 January 2016.

20 A.E. Yamin, 'Beyond compassion: The central role of accountability in applying a human rights framework to health', *Health and Human Rights* 12 (2008) 1-20.

In addition to judicial mechanisms there are many different alleys for seeking accountability for health inequalities.²¹ It is interesting to see how some governmental and non-governmental organisations (NGOs) break new ground in showing how human rights can be instrumental in addressing health-related concerns. An interesting example concerns the 'Equality and Human Rights Impact Assessment' (EHRIA) of Aberdeen City Council (Scotland), which assesses the impact of the Council's policies, procedures and functions on the various population groups within Aberdeen City. As a framework of assessment, the principles of direct and indirect discrimination are mostly used, but also the rights set out in the European Convention of Human Rights (ECHR) and the Convention on the Rights of the Child (CRC), as well as national legislation. By assessing all proposals, including new functions, policies and procedures against the light of the EHRIA, Aberdeen City Council attempts to generate socio-economic changes for several vulnerable groups in the community.²²

Civil society organisations have also made worthwhile efforts to embed human rights language in their policies and strategies. For example the British consumer organisation Health Watch has adopted a rights-based approach in its strategies.²³ The British Institute of Human Rights, using the rights in the British Human Rights Act, has focused specifically on the human rights that play a role in healthcare settings.²⁴

Furthermore, an NGO called 'Seven Towers Residents Group' in Northern Ireland seeks to improve the living conditions in the 'Seven Towers' area, rated as one of the most deprived areas in terms of unmet housing needs in the whole of Northern Ireland. This organisation uses the framework of the right to housing and a set of self-set indicators and benchmarks to assess and monitor the housing conditions of the residents.²⁵

21 H. Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (Essex: University of Essex Human Rights Centre/Open Society Institute, 2008).

22 Aberdeen City Council Equality and Human Rights Impact Assessment, http://www.aberdeencity.gov.uk/council_government/equality_and_diversity/eqd_ehria.asp, retrieved 4 January 2016.

23 Health Watch, <http://www.healthwatch.co.uk/rights>, retrieved 19 January 2016.

24 British Institute of Human Rights, <http://www.bihhr.org.uk/projects/human-rights-in-healthcare-public-sector>, retrieved 19 January 2016.

25 Seven Towers Project — Participation and the Practice of Rights, <http://www.pprproject.org/right-to-housing>, retrieved 19 January 2016.

4 Conclusion

Human rights law in the way it is currently defined offers a clear and applicable framework for addressing health inequalities. The internationally recognised 'right to health', in conjunction with the other health-related human rights, captures most elements of social determinants of health. When it comes to seeking accountability for these matters, a number of promising judicial and non-judicial cases show us how human rights can be instrumental in addressing these determinants of health.

There is still much work to be done when it comes to bridging the conceptual and more practical gaps between human rights law and the need to address inequalities in health. From a normative perspective, we must more fully perceive the relevant health-related rights in conjunction with each other, for example by recognising the importance of a right to education for health and for the protection of health. When it comes to holding the state and other actors accountable, we must explore the best ways to address the responsibilities of all stakeholders with respect to such matters.

Public health specialists and human rights experts should work together to reach a common understanding of how human rights could more effectively be applied to address health inequalities, both between and within countries. This requires a certain openness and flexibility when it comes to understanding and applying mutual concepts and ideas, and a willingness to take on board the language and tools developed in other disciplines.